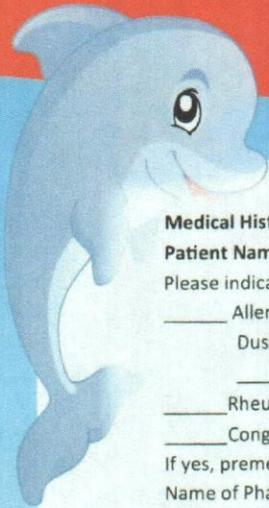


**1367-B EAST GARRISON BOULEVARD
 GASTONIA, NC 28054-5144
 980.320.8479
 WWW.GASTONIAPEDIATRICDENTISTRY.COM**



Medical History

Patient Name: _____ **Date of Birth:** _____

Please indicate with a YES or NO. Does your child currently have/previously had any of the following health problems?

- | | |
|---|---|
| <input type="checkbox"/> Allergies (Latex, Penicillin, Eggs, Nuts, Food, Dust, Drug, Unknown) If yes, please list _____ | <input type="checkbox"/> High/Low Blood Pressure _____ |
| <input type="checkbox"/> Rheumatic Fever/ Rheumatic Heart Disease _____ | <input type="checkbox"/> Any Current/ Recent Injuries _____ |
| <input type="checkbox"/> Congenital Heart Disease or Heart Murmur _____ | <input type="checkbox"/> Childhood Illness _____ |
| If yes, premed needed? _____ | <input type="checkbox"/> Blood Transfusion _____ |
| Name of Pharmacy: _____ | <input type="checkbox"/> Any Prolonged Bleeding/Bruises Easily _____ |
| Pharmacy Phone Number: _____ | <input type="checkbox"/> Kidney or Bladder Problems _____ |
| <input type="checkbox"/> Glandular or Hormonal Problems _____ | <input type="checkbox"/> Tuberculosis or Pneumonia _____ |
| <input type="checkbox"/> Diabetes/Blood Sugar Problems _____ | <input type="checkbox"/> Liver Problems, Jaundice or Hepatitis _____ |
| <input type="checkbox"/> Arthritis or Rheumatism (painful, swollen joints) _____ | <input type="checkbox"/> Accidents or Severe Infections _____ |
| <input type="checkbox"/> Convulsions, Seizures, Fainting or Epilepsy _____ | <input type="checkbox"/> Psychological or Emotional Problems _____ |
| <input type="checkbox"/> Anemia or Blood Disorders _____ | <input type="checkbox"/> Any Pending/Recent Surgery _____ |
| <input type="checkbox"/> Asthma or Hay Fever (Please indicate) If yes, please list any current medications: _____ | <input type="checkbox"/> Speech, Learning, or Hearing Disorders _____ |

Are your child's Immunizations current? _____

Does your child have any special needs or special circumstances? (i.e., Autism, Cerebral Palsy, Downs Syndrome): _____

Please list any and all current medications: _____

Dental History

Date of last dental visit _____ By Dr. _____

Do you have any current records (including x-rays) from another practice? Yes No

Has your child complained about any dental problems? _____

Any injuries or surgeries to mouth, teeth, head? Yes No If yes, please describe _____

Does your child still take the bottle or sippy cup? _____

What does your child usually drink? _____

Does your child brush daily? Yes No How often? _____

Do you assist your child with brushing? Yes No How often? _____

Is Dental Floss used? Yes No

Please check each box if your child has any of the following mouth habits

- Thumb sucking Mouth Breathing Pacifier Nail Biting Finger Sucking Grinding Other _____

How does your child receive fluoride?

- Water Supply Dentist Toothpaste Vitamins Tablets None

Other: _____

Child's attitude toward dentistry: _____

Reason for today's visit/chief concern: _____

I hereby certify that all of the above information is correct and true. Because the above named child is a minor, it is necessary that a signed permission be obtained from a parent or guardian before any necessary dental treatment can begin. Furthermore, I will be responsible for any professional fee incurred for dental services for my child. I understand that I am responsible for all charges whether or not covered by insurance. All balances over 90 days are subject to a 1.8% per month finance charge.

Signed _____ Date _____

Relationship to patient _____