

Susanville Dental Specialties Confidential Patient Medical and Dental History

REMINDER: Each child will need a separate Patient Medical and Dental History form. Extra forms can be found on our website under the 'forms' tab labeled Medical History Form.

Patient _____

Date of Birth _____

Physician's Name _____ Phone _____ Last Visit _____

Has patient ever been under the extended care of a physician or had any surgeries? Yes No

If yes, please explain: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Conditions (murmur, etc.) | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Infections |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Eyesight Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infections | <input type="checkbox"/> Speech Impairments |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Other _____ | | |

Is the patient currently on any medications? Yes No If yes, list: _____

Is the patient allergic to any foods or medicines? Yes No If yes, list: _____

Last Dentist's Name _____ Phone _____ Last Visit _____

DENTAL AND ORTHODONTIC HISTORY

Were any x-rays taken at patient's last dental visit? Yes No _____

Has patient had any problems with dental exams or treatment in the past? Yes No _____

Has patient had any cavities in the past? Yes No _____

Does patient brush their teeth daily? Yes No _____

Does patient currently take a fluoride supplement tablet, gels, rinses, etc.? Yes No _____

Does patient floss their teeth daily? Yes No _____

Has patient ever received local anesthetic? Yes No _____

Has patient ever had sealants placed? Yes No _____

If applicable: Has parent been diagnosed with tooth decay in past two years? Yes No _____

Has patient experienced any trauma to the teeth? (falls, blows, chips, etc.) Yes No _____

If yes, please explain: _____

Please describe patient's diet (regular/favorite foods) _____

Has patient ever sucked thumbs or fingers? Yes No _____

Does patient have speech problems? Yes No _____

Has patient ever been informed of any extra or missing teeth? Yes No _____

Has patient ever had a previous orthodontic exam? Yes No _____

Have any family members ever needed orthodontics in the past? Yes No _____

Does patient have any pain in their jaw? Yes No _____

Does patient have any popping or clicking of the jaw joint? Yes No _____

Any orthodontic concern? _____

Please tell us about the patient's interests (favorite sports, hobbies, TV shows, travel, movies, etc.)

Thank you for taking the time to fill this out!

I certify that the above information is complete and accurate.

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____