CHILDREN'S DENTISTRY GROUP, LLC

Sarah A. Mahmoud, D.M.D.
Paul D. Herer, D.M.D., M.S.
Melissa J. Patenio, D.D.S., M.S.
Anupama Krishnamurthy, D.D.S.

CONFIDENTIAL HEALTH HISTORY FORM

Please fill out all applicable information completely.

Patient's Name: ______________________ Nickname: ______________ Birthdate: ____________

Residence/Street: ______________________ Home Phone: ______________ Sex: ________

City: ______________ State: ________ Zip Code: ______ E-mail: ____________________

Father's Name: ______________________ Employer: ______________________ SS#: ____________

Cell Phone: ____________ Work Phone: ____________ Birthdate: ________ Marital Status: S / M / D / W

Mother's Name: ______________________ Employer: ______________________ SS#: ____________

Cell Phone: ____________ Work Phone: ____________ Birthdate: ________ Marital Status: S / M / D / W

Elect to receive quarterly newsletter? Yes No (Please circle) Whom may we thank for referring you? ______________

MEDICAL HISTORY

Physician's Name: ______________________________ Phone: ____________________

Address: ______________________________ Date of Last Medical Exam: ____________

Are your child's immunizations up to date? ☐ Yes ☐ No Is your child currently taking any medications? ☐ Yes ☐ No

Medications: (Please include dose & frequency) ________________________________

Significant injuries (such as head or teeth, broken bone, car accidents)? Please describe: ________________

________________________ Height: ______________ Weight: ______________

DOES THE PATIENT HAVE OR HAD ANY OF THE FOLLOWING?

Please indicate with an (X)

- ☐ Allergies (skin rashes, medication, food, dust, other ____________)
- ☐ Anemia or blood problems (Sickle Cell)
- ☐ Arthritis/Joint pain
- ☐ Asthma/Breathing problems
- ☐ Bleeding problems
- ☐ Bone or Muscular problems
- ☐ Bronchitis
- ☐ Cancer/other tumors
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Ear/Hearing
- ☐ Endocrine/Glandular problems
- ☐ Eye/Vision problems
- ☐ Handicaps (mental, physical, emotional)
- ☐ Heart defects
- ☐ Hepatitis/Jaundice
- ☐ Immuno Suppressive (A.I.D.S.) Disease
- ☐ *Hospitalizations*:______________________ ______________________
- ☐ Kidney/Urinary Tract problems
- ☐ Learning Disorders__________
- ☐ Measles
- ☐ Mumps
- ☐ Nervous/Seizure problems
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Radiation Treatments
- ☐ Scarlet Fever
- ☐ Stomach/Digestive problems
- ☐ Venereal Disease

DENTAL HISTORY

Current Dentist's Name: ______________________________ Phone: ____________________

Address: ______________________________ Date of Last Dental Exam: ____________

Has the patient had any unfavorable dental experiences? YES NO If yes, please explain: ______________

Chief Oral Complaint: ________________________________

DOES THE PATIENT HAVE OF USE ANY OF THE FOLLOWING?

Please indicate with an (X)

- ☐ Traumatic injury to mouth or teeth
- ☐ Sensitivity to cold/hot/sweet/pressure
- ☐ Bleeding gums? How long__________
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around the ears
- ☐ Bad Breath
- ☐ Complications from extractions
- ☐ Topical Fluoride Treatment
- ☐ Orthodontic Treatment or Supplements
- ☐ Mouth breathing
- ☐ Bedtime nursing bottle
- ☐ Toothbrush texture____________
- ☐ Brushing frequency ____________
- ☐ Dental Floss frequency __________
- ☐ Disclosing tablets/solutions
- ☐ Between meal snacks
- ☐ Well-balanced diet
- ☐ Oral habits: thumb sucking, nail biting, pacifier, cheek biting, tongue thrusting

Describe any current medical treatment including drugs taken, even though not listed above:

____

____

Is there anything that you feel Children's Dentistry Group should know about the patient?

____

I certify that I have read and understand the above question. I will not hold Children's Dentistry Group, LLC responsible for any errors or omissions I may have made in completion of this form.

Signature of Person Completing Form: ______________________________

Relationship to Patient: ______________________ Date: ______________