

WELCOME

•Patient Name: _____

•DOB: _____ • Phone #: _____

Conditions	Does the patient have any MEDICAL CONDITIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>(For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal Allergies, ETC)</small>
	If YES, what conditions?
	Does the patient have any HEART conditions? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>(For example: Heart Murmur, congenital Heart Defects, ETC)</small>
	If YES, what conditions?
	Does the patient require an ANTIBIOTIC before being seen? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If YES, did the patient take the antibiotic? <input type="checkbox"/> YES <input type="checkbox"/> NO</small>
	Does the patient have any history of Cancer or Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO
	If Yes, please explain:
Allergies	Is there any possibility of pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Does the patient have an ALLERGY to LATEX? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Does the patient have any OTHER ALLERGIES? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>(For example: Animals, Foods, Medications, Nickel, ETC)</small>
If YES, what allergies?	
Medications	Is the patient currently taking ANY Medications/Vitamins? <input type="checkbox"/> YES <input type="checkbox"/> NO
	If Yes, what medications/Vitamins?
	Why is the patient taking this medication (what condition is it for)?
Dental Concerns	Do you (or the patient) have any DENTAL CONCERNS? <input type="checkbox"/> YES <input type="checkbox"/> NO
	If YES, what concerns do you have?
Surgery	Has the patient had any surgeries/hospitalizations in the past 2 years? <input type="checkbox"/> YES <input type="checkbox"/> NO
	If YES, what was the approximate date and reason?

UPDATE ADDRESS: _____

LEGAL GUARDIAN: _____

It is important that the medical and dental information provided is current and accurate. In order for our doctors to provide safe and effective dental care, it is necessary for them to know your dental history. Thank you for taking your time to fill out this form completely.

DENTAL HISTORY

Name of Previous Dentist _____ **Phone #** _____

How long has it been since you've seen a dentist? _____

Reason for your dental visit today _____

Have you had any periodontal (Gum) problems?	YES	NO
Do your gums bleed or feel irritated or tender?	YES	NO
Do you floss regularly?	YES	NO
Do you have headaches, earaches or neck pain?	YES	NO
Have you worn braces on your teeth?	YES	NO
Are you happy with the appearance of your teeth?	YES	NO

If not, please explain _____

Are your teeth sensitive to (please circle)	HOT	SWEETS
	COLD	PRESSURE

I certify that the information I have given is correct to the best of my knowledge. If any changes do occur I will notify Smiles for Kids and update my file.

Signature: _____ Date: _____