Health History Form

Pediatric Dentistry of Flower Mound
972-724-1617 • 2701 Old Settlers Road • Flower Mound, TX 75022

Patient Information

Please complete this form thoroughly because this information is of great value in helping us to be better understand and care for your child.

Appointment Date _____

Patient Name _____ Nickname _____
LAST FIRST MI

❑ Male ❑ Female Siblings & Ages _____

Birthdate _____ E-mail _____ Age _____

Home Phone ( ) _____ School _____ Grade _____ Weight _____

Address _____
STREET APT NO.

_____
CITY STATE ZIP

Please indicate if your child has ever had any of the following.

L *PRE-MED NEEDED	L Artificial Joints	L Heart Murmur	L Pulmonary Stenosis
L ADHD	L Asperger's Syndrome	L Heart/VSD	L Radiation Treatment
L AIDS	L Asthma	L Hemophilia	L Respiratory Problems
L Allergies	L Autism	L Hepatitis	L Rheumatic Fever
L Allergy: Amoxicillin	L Behavioral Problems	L High Blood Pressure	L Shunt
L Allergy: Ceclor	L Blood Disorder	L Hospitalization	L Sinus Problems
L Allergy: Codeine	L Cancer	L Immunizations	L Skin Condition
L Allergy: Drug	L Cerebral Palsy	L Kidney Disease	L Speech Problems
L Allergy: Food	L Diabetes	L Liver Disease	L Stomach Problems
L Allergy: Gluten	L Dizziness	L Lung Problems	L Stroke
L Allergy: Latex	L Downs Syndrome	L Medications	L Surgeries (explain)
L Allergy: Penicillin	L Epilepsy	L Manses' Onset	L Thyroid Condition
L Allergy: Sulfa	L Head Injuries	L Mental Disorders	L Tuberculosis
L Allergy: Erythromycin	L Hearing Problems	L Nervous Disorders	L Tumors
L Anemia	L Heart ASD	L Pacemaker	L Ulcers
L Arthritis/Rheumatism	L Heart Condition	L Pregnancy	L x-OTHER

If you have selected any conditions or alerts above for your child, please clarify/explain below:

_____

_____

Pediatrician Name _____ Last Visit _____ Phone _____

Has your child been seen by another dentist? ❑ No ❑ Yes, Name _____ Phone _____

Date of Last Visit _____ Cleaning ❑ Yes ❑ No X-rays ❑ Yes ❑ No Sealants ❑ ❑ No Date of - Bitewings _____ Pano _____

Has your child had an unfavorable dental experience? _____ If yes, please specify: _____

Does your child have a past or <u>current</u> history of thumb/finger sucking? ❑ Yes ❑ No Pacifier? ❑ Yes ❑ No

Was your child breast fed? ❑ Yes ❑ No Bottle fed? ❑ Yes ❑No Age discontinued: _____

What is your home water source? ❑ Public System ❑ Private Well ❑ Other _____

Consent for Services

I, the undersigned parent, or legal guardian of the above-named patient, hereby authorize the completion of all agreed upon treatment and the use of those methods appropriate thereto. I understand that my child's dental condition and treatment options will be discussed prior to completion.

I have disclosed my child's health history in its entirety including allergies, reactions to medicine, heart condition, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedures and course of treatment.

I authorize Pediatric Dentistry of Flower Mound, associates, and any other dental auxiliary's or medical professional to perform dental procedure(s) or treatment(s) on my child as listed on his/her treatment plan. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedure on my child.

I understand that as the parent/legal guardian of the above-named minor, by signing this form I claim myself as the responsible party for any charges or bill incurred on my child's behalf.

I confirm that I understand this form and the information therein.

_____ Date _____ Relationship to Patient _____
SIGNATURE OF PARENT OR GUARDIAN