STARSHIP PEDIATRIC DENTISTRY

Individual Child Form: Please fill out one for for each child being treated at our office.

Patient's Name: _____ Nickname: _____

Date of birth: _____ Age: _____ Birth gender: _____

Pediatrician/Medical Specialist Information:

Pediatrician name: _____ Office Name: _____

Name and Contact of specialists, if applicable: _____

Please review carefully and check ☑ if your child has any history, or condition related to, any of the following:

☐ Anemia	☐ Chronic Sinusitis	☐ Hyperactivity	☐ Snoring
☐ Asthma	☐ Diabetes	☐ ADHD/ADD	☐ Speech/Hearing
☐ Autism	☐ Enlarged Tonsils	☐ Latex Allergy	☐ Thyroid
☐ Bladder/Kidney	☐ Epilepsy/Seizures	☐ Liver/Hepatitis	☐ Tuberculosis
☐ Bleeding Disorders	☐ Fainting	☐ Pregnancy (teens)	☐ Vision Disorders
☐ Bone Disorders	☐ Growth Problems	☐ Prosthetic Heart Valve	☐ Other _____
☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever	☐ **None**
☐ Cerebral Palsy	☐ HIV+/AIDS	☐ Sickle Cell	

Health History:

Yes / No

☐ ☐ 1. Is your child taking any medications (prescription, over-the-counter, vitamin supplements)?
If yes, please list: _____

☐ ☐ 2. Is your child allergic to (please explain if yes to any)…
- Any medications? _____
- Any foods? _____
- Other? _____

☐ ☐ 3. Has your child ever been hospitalized or had surgery? Please explain: _____

☐ ☐ 4. Does your child have any mental, developmental, or physical impairment?
Please explain: _____

☐ ☐ 5. Have you ever been told you child has a heart murmur or other heart condition?
Please explain: _____

☐ ☐ 6. If you answered yes to #5, were you told your child needs antibiotic prophylaxis?

☐ ☐ 7. Has your child been diagnosed with any other illness not yet discussed in this form?
Please explain: _____

☐ ☐ 8. Are your child's immunizations up to date? If not, please explain: _____

☐ ☐ 9. Are patient's preferred pronouns, consistent with birth gender? If not, please list: _____

Dental History:

Yes / No

☐ ☐ 1. Is this your child's first dental visit? If not, date and location of last visit ? _____
_____

☐ ☐ 2. Has your child ever had an unfavorable experience or reaction to a previous dental visit?
Please explain: _____

☐ ☐ 3. Does your child take fluoride supplements?

☐ ☐ 4. Has your child complained of recent dental pain? Please explain: _____

☐ ☐ 5. Any other dental concerns or comments? _____

Parent Signature: As this child's parent or legal guardian, I acknowledge that the information I have given is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment.

Legal Guardian's signature: _____. Print name: _____ Date: _____

Doctor's Signature: _____ Doctor's name: _____ Date: _____