Lithonia Pediatric Dentistry - Stonecrest
Health History

Patient name ______________________________ ☐ male ☐ female Date of birth _________ Age ____
Last First MI

*** Please ***CIRCLE*** yes or no for the correct answer to the questions below***
Each answer must be circled individually

Dental review and update:

Yes No Any injury to head, teeth, or mouth ____________________

Yes No Any habits: thumb/finger sucking pacifier

Yes No Any sores, swelling or discomfort to teeth ____________________

Yes No Ever slept with a bottle or wake up for juice

Yes No Any dental concerns to report ____________________

Yes No Any unhappy dental experiences ____________

Who participates in brushing: ☐ patient only ☐ parent only ☐ parent and child ____ times per day Flossing per day ____

Medical review and update:

Has the patient ***had*** (list the year beside the item) or ***currently have*** any of the following:

Yes	No	Arthritis	Yes	No	Asthma	Yes	No	Autism	Yes	No	Cancer
Yes	No	Cerebral Palsy	Yes	No	Cleft lip/palate	Yes	No	Diabetes	Yes	No	Drug/Alcohol abuse
Yes	No	Emphysema	Yes	No	Epilepsy	Yes	No	Fainting spells	Yes	No	Hay fever
Yes	No	Hearing problems	Yes	No	Heart trouble	Yes	No	Hemophilia	Yes	No	Hepatitis or liver disease
Yes	No	HIV or AIDS	Yes	No	High Blood Pressure	Yes	No	Hives or rash	Yes	No	Kidney trouble
Yes	No	Meningitis	Yes	No	Pneumonia	Yes	No	Psychiatric care	Yes	No	Rheumatic fever
Yes	No	Tuberculosis	Yes	No	Shunt (heart or brain)	Yes	No	Thyroid Disease	Yes	No	Sickle cell anemia \ trait

Yes No Heart murmur ____________________

Yes No Developmental disability: Please list ______________

Yes No Congenital heart disease: Please list____________

Yes No Is the patient allergic to any ***medications*** or ***latex***?

Please list ____________________

Yes No Is the patient presently taking any medications.

Please list ____________________

Yes No Has the patient had a serious illness or operation?

Please list ____________________

Yes No Has the patient ever been hospitalized?

Please list reason ____________________

Yes No Has the patient ever required a blood transfusion?

Yes No Are the patient's immunizations up to date?

Yes No Does the patient ***currently have*** any of the following: **circle**

ring worm strep throat pink eye cold

Yes No Pregnant ______ months

To the best of my knowledge, all of the preceding answers are true and correct. I give my consent for the dental treatment of the child named on this form, with the understanding that acceptable pediatric dental techniques will be used for the management and completion of treatment. I further acknowledge that I have the authority to give consent for the treatment of this child. As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

______________________________ ______________ _________
signature of person giving consent relationship to child date

____
print name

area below for 6 month update

update review on ____________ by ______________________ Have any changes occurred since the last visit. Yes No

Please note any changes to history with the date the change occurred.