Saddle Rock Pediatric Dentistry
22986 E. Smoky Hill Rd.
Aurora CO 80016-1382
(303)690-1690

Medical & Dental History Form

Patient Name: Last | First | MI | Preferred Name

Date of Birth:

We welcome you and your child to our dental practice. Please complete this form to the best of your ability; this information is of great value to help us better understand and care for your child.

Why did you bring the child to the dentist today?

Is the child in pain?

◯ Yes ◯ No

Does the child require antibiotics prior to dental treatment?

◯ Yes ◯ No

Describe the child's current physical health:

◯ Good ◯ Fair ◯ Poor

Is the child currently under the care of a physician?

◯ Yes ◯ No

Explain if needed:

Child's Physician's name & phone number:

Last Physician Visit:

List all medications/drugs the child is currently taking:

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List all drugs/materials the child is allergic to:

Please indicate if the child has had any of the following:

- ☐ Abnormal bleeding
- ☐ Any operations
- ☐ Congenital heart defect
- ☐ Handicaps/disabilities
- ☐ Hemophilia
- ☐ Kidney/liver problems
- ☐ Immunizations current
- ☐ ADHD/ADD
- ☐ Cancer
- ☐ Developmental delay/speech delay
- ☐ Hepatitis
- ☐ Rheumatic fever/Scarlet fever
- ☐ Adopted
- ☐ Any hospital stays
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart murmur
- ☐ High/ low blood pressure
- ☐ Sickle cell disease/ trait
- ☐ Allergies to any drugs
- ☐ Artificial bones/joints
- ☐ Seizures/Epilepsy
- ☐ Hearing impairment
- ☐ HIV+/AIDS
- ☐ Tuberculosis (TB)

Discuss any medical problems the child has or has had:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Is the child's water fluoridated?
- ☐ Does the child take fluoride supplements?
- ☐ Has the child ever had pain/tenderness with his/her jaw joint (TMJ/TMD)?
- ☐ Does the child brush his/her teeth daily?
- ☐ Does the child floss his/her teeth daily?

If any of the previous questions are marked, please explain:

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How do you think the child has reacted to past medical or dental procedures?

◯ Very good ◯ Good ◯ Poor ◯ Very poor ◯ Unknown

How do you expect the child to react in the dental chair?

◯ Very good ◯ Good ◯ Poor ◯ Very Poor ◯ Unknown

Has the child ever had a serious/difficult problem associated with previous dental work?

◯ Yes ◯ No ◯ First Visit

Please mark any of the following to indicate Yes in response to the question:

☐ Has the child ever had a toothache?
☐ Has the child had any orthodontics?
☐ Is there a family history of missing teeth?
☐ Does s/he have any problems with eating?
☐ Has the child ever had a blow to the teeth?
☐ Has Mom or Dad had a lot of decay?

If any of the previous questions are marked, please explain:

Please mark Yes if the child does/did experience any of the following:

☐ Lip sucking/biting
☐ Mouth breather
☐ Thumb/finger sucking
☐ Nursing bottle/sippy cup habits
☐ Tongue thrust
☐ Clenching/grinding teeth
☐ Breast fed
☐ Nail biting
☐ Pacifier use

If any of the previous are checked, please explain:

When was the child's last visit to the dentist (if to a different office)?

What was done at your child's last dental visit (if to a different office)?

Prior Dentist's name & phone number:

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Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. If I become aware of a change in my child's health, I will inform the office at my next dental appointment without fail.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____