STATEN ISLAND PEDIATRIC DENTISTRY

195 Bridgetown Street, Staten Island, NY (718)-761-7316

Medical and Dental History Form

Child Patient Information		
Child's Full Name (Last) (First) (Middle)		Referred By:
Home Address	City	State/Zip
Primary Reason for Visit		
Home Phone	Email Address	

Child's Medical History		
Date of Birth month / day / year	Weight	School/Grade
Child's Physician (Name/Address)		
Is your child taking medication? (Please explain)		
Has your child had any surgery, serious medical problems, hospitalizations or emergency room visits? (Please explain)		

Has your child had any of the following? (Check all that apply)

□ Heart problems	□ Rheumatic Fever	□ Glandular Problems	□ ADD/ADHD
□ Diabetes	□ Brain Injury	□ Unconsciousness	□ Tonsil/Adenoid
□ Lung Disorders	□ Kidney Problems	□ Liver Problems	Problems / Snoring
□ Hepatitis	□ Blood Transfusions	□ AIDS/HIV+	□ Autism Spectrum
□ Hearing problems	□ Vision Problems	□ Emotional Issues	Disorder (ASD)
□ Seizures	□ Asthma	□ Bleeding Disorders	

□ Other _____

Is your child allergic to any food or drug? (Please explain)		
Does your child receive occupational, speech or physical therapy? (Please explain)		
Was the term of pregnancy and birth normal with respect to your child? (Please explain)		
Has your child had any unfavorable or undesirable reaction to previous dental or medical care? (Please explain)		

Child's Dental history		
Has your child received dental care before? Yes / No	If yes, at what age?	Reason?
How was your child's behavior at your last dental care visit?		
Has your child experienced any major injury to the face or teeth? (Please explain)		
Did your child ever sleep with a bottle? Yes / No	If yes, what did it contain?	
Did your child ever use a pacifier? Yes / No	If yes, until when?	
Did your child ever suck his/her fingers? Yes / No	If yes, until when?	

I certify the above information is true and correct to the best of my knowledge

Signature	Relationship			Date		
Reviewed and Updated by Parent/Guardian	Intitials & Date	Intitials & Date	Intitials & Date	Intitials & Date	Intitials & Date	Intitials & Date
Reviewed by dentist	Intitials & Date	Intitials & Date	Intitials & Date	Intitials & Date	Intitials & Date	Intitials & Date