Kids Dental Barn

Name of Patient____ Age_____________

Patient Medical History

Name of Physician_________________________________ Office Phone (_____) ________-____________

Approximate date of last physical exam?____

1. Is your child under any medical treatment now?..YES/NO
2. Has your child had any major operations? YES/NO If so, what?_________________________________
3. Has your child ever been hospitalized? YES/NO If so, for what?_______________________________
4. Does your child have any allergies to medication? YES/NO If so, what?__________________________
5. Does your child have any allergies to Latex?..YES/NO
6. Does your child have any other allergies? YES/NO If so, what?________________________________
7. **Has a physician ever informed you that your child has/had:**

A Heart Condition..........................YES/NO	Stomach/GI Disorders....................YES/NO
High Blood Pressure......................YES/NO	Yellow Jaundice or Hepatitis..........YES/NO
Respiratory Disease (asthma)........YES/NO	HIV Positive or AIDS.........................YES/NO
Diabetes..YES/NO	Behavioral Disorders......................YES/NO
Rheumatic Fever.............................YES/NO	Developmental Delay.....................YES/NO
Rheumatism or Arthritis................YES/NO	Down Syndrome.............................YES/NO
Tumors or Growths........................YES/NO	Autism...YES/NO
Any Blood Disease.........................YES/NO	Failure to Thrive.............................YES/NO
Any Liver Disease............................YES/NO	Other______________________________
Any Kidney Disease........................YES/NO	___________________________________

8. Is your child currently taking any medications? YES/NO If so, what?________________________
9. Does your child have any bleeding disorders?..YES/NO
10. Does your child have any history of fainting?...YES/NO
11. Does your child have a history of seizures?...YES/NO
12. Has your child ever had a radiation treatment for cancer?...YES/NO
13. Is your child in general good health at this time?..YES/NO

Patient Dental History

14. Has your child ever been to the dentist?..YES/NO

If so, what is the approximate date of last visit?____

15. What is the reason for your child's visit today? ____
16. Has your child ever had fillings/extractions done at the dentist?..YES/NO

If so, was local anesthetic used...........................YES/NO Were they sedated................................YES/NO

17. Has your child had any trauma to their mouth?...YES/NO
18. Does your child have a history of sores in or around their mouth?...YES/NO
19. Do your child's gums bleed when they brush?...YES/NO
20. Does your child have any habits?(grinding, thumb sucking ,bottle)..YES/NO

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my Childs medical status.

I authorize the Kids Dental Barn and associates to perform the necessary dental services my child may need.

Signature____ Date____________________

Doctor's Signature____ __________Date___________________