Pediatric Dentistry for Infants, Children & Teens, P.C.
Wayne R. Miller, DMD
Health History

Patient name _____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 Sleep with bottle or use a sip cup

Yes No Any dental concerns to report _____ Yes No Any unhappy dental experiences:_____

Medical review and update: _____

Has your child had 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 Hives or rash	Yes No Kidney trouble	Yes No Meningitis
Yes No Pneumonia	Yes No Psychiatric care	Yes No Rheumatic fever	Yes No Sickle cell anemia \ trait
Yes No Shunt (heart or brain)	Yes No Thyroid Disease	Yes No Tuberculosis	Yes No Heart murmur

Yes No Congenital heart disease: Please list_____ Yes No Developmental disability: Please list _____

Yes No Is your child presently taking any medications.
Please list _____

Yes No Is your child allergic to any medications.
Please list _____

Yes No Has your child ever been hospitalized?
Please list reason _____

Yes No Has your child had a serious illness or operation?
Please list _____

Yes No Are your child's immunizations up to date?

Yes No Has your child ever been tested for HIV (AIDS).
If Yes please circle result: Positive Negative

Yes No Has your child ever required a blood transfusion?

Yes No Does your child have any of the following: circle
ring worm strep throat pink eye

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

update review on ____________ by _____ Have any changes have occurred since last visit. Yes No
Please note any changes to history with the date the change occurred.