

Dental & Medical History Form

Please fill out and bring with you to appointment.
 Or Fax it to 610-337-3863 Make sure you sign at the bottom if faxing.

Patient's Name				Birth date & age	
Reason for office visit?					
Has the patient ever had a serious /difficult problem associated w/ previous dental treatment? Explain.					
Name of previous dentist, if any					
Does the patient brush daily?				Does the patient floss daily?	
Does patient take fluoride supplements?				Is your water supply fluoridated?	
Patient's Primary Doctor & Tel#					
Has the patient ever had one of the following (Y or N) Please explain YES answers					
Y / N	Condition	Explain "yes"	Y / N	Condition	Explain "yes"
	Heart Murmur			Other Heart Problems?	
	Cancer			Convulsions / epilepsy	
	Diabetes			Abnormal Bleeding	
	Rheumatic fever			Hearing Impairment Or Ear Problems	
	HIV+ / AIDS			Family history of missing or extra teeth	
	Hemophilia			Any stays in a hospital or operations	
	Asthma			Kidney or Liver Problems	
	Hepatitis			Handicaps or Disabilities	
	Tuberculosis			Latex Allergy	
	ADD or ADHD			Artificial joints or valve replacements	
Please detail any serious medical problems or hospital stays :					
List all drugs patient is currently taking					
List any drug Allergies or other Allergies					
For pediatric patients, does child have any of the following habits? Y or N		Thumb or finger sucking?	Lip Sucking or Biting, Nail biting?	Still Nursing or use a Bottle?	Uses a Pacifier?
		Y / N	Y / N	Y / N	Y / N

I understand that the information 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 the office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

X _____ /date: _____

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child has any questions, please feel free to ask us any time.

UMDA USE Only - Reviewed by: (Initials & Date) _____, _____, _____, _____