



Pediatric Health History

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MINT.



dental studio

Patient Information

* First Name _____ Middle Initial _____ Last Name _____

Medical History

* Patient's Primary Care Physician

Physician's Name _____ Physician's Phone Number _____

Physician's Address (Street or PO Box, City, State, Zip Code)

* What is the date (or approximate date) of patient's last medical exam? _____

* Has the patient ever had complication following dental treatment or had negative dental experiences?
yes no If yes, please explain.

Behavioral / Developmental

* Has the patient ever been diagnosed as having behavioral issues, ADD, ADHD, Autism Spectrum, or Developmental Delay? yes no

If you answered yes, please provide additional details. What works best for us to help your child through their visit?

Lungs

- * Has the patient ever had or been treated for Asthma or any other breathing problems? yes no
If you answered yes, please specify which condition the patient has and provide any other additional details:

Other Health

- * Are there any other conditions the patient has that we should be aware of? yes no
If you answered yes, please specify which condition the patient has and provide any other additional details:

- * Please list all medications the patient is currently taking (including over-the-counter and herbal products). Also include dosage, frequency, and the reason the patient is taking the medication.

- * Please list any allergies and/or bad reactions the patient has had. Include what the patient reacted to, what happened to the patient, and how severe it was.

* Please list all operations and/or hospitalizations the patient has had and approximate dates.

Acknowledgment

To the best of my knowledge, all of the proceeding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail. 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 health.

Relationship of person completing this form to the patient. _____

Signature

Date