WESTFIELD PEDIATRIC DENTAL GROUP
PATIENT HEALTH HISTORY

We would like to WELCOME you and your child to our office. We are a practice based on preventative care. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime. Please PRINT all information CLEARLY.

Patient's Full Name: _____ Age: _____ Date of Birth: ___/___/___
First Middle Last
Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: (___) _____-_____ Sex :(M) (F) Weight: _____lbs. E-Mail: _____

Mother's Cell Phone # _____ Father's Cell Phone # _____ Other # _____

Name of Physician: _____ Phone: (___) _____-_____ Name & Phone # of Pharmacy: _____

Whom may we thank for your referral? **(please specify)**

1. Sibling _____
2. Internet _____
3. Friend/Word of mouth (Name) _____
4. Dr. _____
5. Newspaper/Magazine _____
6. Insurance _____
7. Yellow pages _____
8. Other _____

DENTAL AND MEDICAL HISTORY

1. What is the chief concern regarding the patients oral health? _____
2. Has the patient had any injuries to the face, mouth, or teeth? _____ Yes No
3. Has the patient had any unusual or unpleasant experiences in a dental or medical office? _____ Yes No
4. Were there any problems during pregnancy, delivery or during the child's first year of life? _____ Yes No
5. Is the child currently under the care of a physician? _____ Yes No
6. Has the child been in the hospital or had surgery/operation? _____ Yes No
7. Is the child currently taking any medicine? (Prescription, Vitamins, OTC, Herbal) If yes, please list. _____
8. **Does your child have ANY allergies?** If yes, please list all allergies and reaction. _____
9. Is your child currently taking fluoride supplements? If yes, please list _____
10. Please discuss any serious medical problems that the child has had: _____
11. Please describe your child's snacking habits (what types of snack and how often they snack): _____
12. Has your child had a history of: (Please circle Yes or No)

*** If yes to any of the asterisk conditions, please call prior to your appointment....premedication may be required.**

Congenital Heart Defects*	Yes No	Mitral Valve Prolapse*	Yes No	Latex Allergy	Yes No
Heart Murmur*	Yes No	Heart Murmur (innocent)	Yes No	Stomach/Intestinal Disorder	Yes No
Respiratory Problems	Yes No	Rheumatic Fever*	Yes No	Attention Deficit Disorder	Yes No
Artificial Bones/Joints	Yes No	Bleeding Disorder	Yes No	Epilepsy	Yes No
Anemia	Yes No	Sickle Cell Anemia	Yes No	Seizures	Yes No
TMJ/TMD Problems	Yes No	Liver Disease	Yes No	Developmentally Delayed	Yes No
HIV/AIDS/ARC	Yes No	Kidney Disease	Yes No	Cancer*	Yes No
Sinus Problems	Yes No	Chronic Ear Infections	Yes No	Hepatitis	Yes No
Scarlet Fever	Yes No	Tonsillitis	Yes No	Autism	Yes No
Glaucoma	Yes No	Snoring	Yes No	Speech Problems	Yes No
Asthma	Yes No	Hearing Impairment	Yes No	Diabetes (please list type)	Yes No ____
Is the patient adopted?	Yes No				

Other (please list): _____

13. Does your child have any of the following habits? Finger Sucking Pacifier Clenching/Grinding Nail Biting Other
14. Is there a history of Missing or an Abnormal Number of Teeth in the Family? If yes, list _____
15. Child's Interests, hobbies or pets _____
16. Please indicate if your child has any special needs or if there are any custodial issues our office should be aware of : _____

Please circle any of the following that may describe your child:

Outgoing	Shy	Stubborn	Anxious	Nervous
Defiant	Curious	Moody	Friendly	Cooperative

I understand the information that I have given is correct to the best of my knowledge and will be held in strict confidence.
I hereby give consent to the dentist and staff to perform the dental treatment necessary to correct any oral problems the above child may have. I have been given an opportunity to ask any questions I might have and all questions have been answered in a satisfactory manner.

Parent/Guardian
Signature _____
Date _____

Dentist
Signature _____
Date _____