specialsmiles
pediatric dentistry
by
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Patient Name: _____

Date of Birth: _____ Height:_____ Weight_____

Pediatrician/PCP:_____ Phone:_____

Date of Last Medical Check-Up:_____ Immunizations Current? ☐ Yes ☐ No

Dental History:

Previous Dentist: _____ Date of Last Dental Visit:_____

Has patient had an injury to the mouth, teeth, or jaw? ☐ Yes ☐ No

Explain: _____

Medical History:

Does patient have / or had any of the following:

Yes	No		Yes	No	
☐	☐	Autism Spectrum Disorder	☐	☐	Failure to Thrive
☐	☐	Skin Problems/Hives/Cold Sores	☐	☐	Limited Mobility
☐	☐	ADD/ADHD	☐	☐	Seizures/Convulsions/Epilepsy
☐	☐	Allergies	☐	☐	Muscle/Joint/Bone Problems
☐	☐	Anxiety/Depression	☐	☐	Congenital Heart Defect/Disease
☐	☐	Genetic Disorders	☐	☐	MRSA
☐	☐	Visual Impairment (excluding glasses)	☐	☐	Thyroid/Glandular Problems
☐	☐	Learning/Communication Problems	☐	☐	TB/Tuberculosis
☐	☐	Eating Disorders	☐	☐	Rheumatic Fever
☐	☐	Heart Surgery	☐	☐	Blood/Blood Product Transfusion
☐	☐	Abnormal Bleeding Issues	☐	☐	Kidney Problems
☐	☐	Born prematurely	☐	☐	Asthma/Breathing Issues
☐	☐	Heart Murmur	☐	☐	Liver Problems
☐	☐	Sickle Cell Trait/Disease	☐	☐	HIV/AIDS
☐	☐	Hearing Impairment	☐	☐	Cerebral Palsy
☐	☐	High Blood Pressure	☐	☐	Varicella Vaccine/Chicken Pox
☐	☐	Hemophilia/Anemia	☐	☐	Diabetes
☐	☐	Hepatitis A, B, C	☐	☐	Other:_____

Does patient have any drug allergies? ☐ Yes ☐ No

If you have checked yes to any of the above, please explain:

_____

_____

Pharmacy: _____ Phone: _____

Is patient currently taking any medications? ☐ Yes ☐ No

Please list all medications and natural remedies:

Medication Name	Dose	Frequency of Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has patient had surgery or been hospitalized? ☐ Yes ☐ No

Hospital Facility: _____ When: _____

Reason: _____

Hospital Facility: _____ When: _____

Reason: _____

The information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. I understand that it is my responsibility to inform Special Smiles Pediatric Dentistry of any changes in medical status.

Parent/Guardian Signature: _____

Relationship to Patient: _____ Date: _____