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NJ Specialty Permit # 5229
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MEDICAL & DENTAL HISTORY

Child's Name _____ Date of Birth _____
Name of child's pediatrician _____
Address of child's pediatrician _____
Telephone # of child's pediatrician _____

1. Was your child born prematurely?_____ 1. Yes No
2. Has your child ever been hospitalized?_____ 2. Yes No
3. If you answered yes, when and for what?_____ 3. Yes No
4. Is your child allergic to any medicine or foods?_____ 4. Yes No
5. Is your child presently taking any medication?_____ 5. Yes No
6. If you answered yes, what medications?_____ 6. Yes No
7. Has your child ever had any of the following? *(circle all that apply)*: **attention-deficit disorder, asthma, anemia, anxiety disorder, blood disease, cancer, depression, diabetes, heart condition, hepatitis, kidney disease, latex allergy, liver disease, nose/throat/tonsil disorder, rheumatic fever, sleep disorder, speech issues, stomach problems, tuberculosis**
8. Have you ever been told by a physician that your child must take antibiotics prior to dental treatment?_8. Yes No
9. Does your child have any other disease or medical issues? If yes, please explain:_____9. Yes No

_____
_____
_____
_____

10. If your child has visited the dentist before, what was the date? *(If today is first time, skip to question 13)* _____
11. Has your child had dental radiographs (X-rays)?_____11.Yes No
12. Has your child had any problems with previous dental treatment?_____12.Yes No
13. At this time, does your child have any of the following oral habits *(circle):*
thumb-sucking digit-sucking bottle sippycup pacifier other
14. Has your child had any type of injury to his/her teeth?_____ 14.Yes No
15. If yes, please explain:_____
16. Is your child experiencing any pain in the mouth or teeth today or in the last few days?_____ 16.Yes No
17. If yes, please explain_____
18. Does your child have a dental condition about which you are especially concerned?_____ 18.Yes No
19. If yes, please explain_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners.

_____ _____ _____
Signature of parent or legal guardian **Date** **(Please print name)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES *(You may refuse to sign this)*

I have been provided with a copy of this office's Notice of Privacy Practices.

_____ _____ _____
Signature of parent or legal guardian **Date** **(Please print name)**