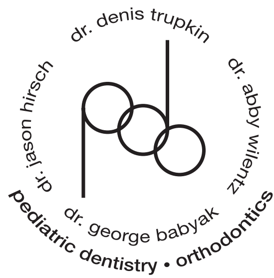

7400 northwest fifth street
plantation, florida 33317
pediatric dentistry 954-581-7883
orthodontics 954-797-4172
fax 954-581-8043

MEDICAL HISTORY

Child's Name ______ Nickname ______

Date of Birth ______ Age ______

School ______ Grade ______ Weight ______ Sex: M ☐ F ☐

Permanent Address ______

City ______ State ______ Zip ______

Home Phone ______ Father's Cell Phone ______ Mother's Cell Phone ______

E-mail ______ What is the best time to be reached? ______

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? YES ☐ NO ☐

Name of Insured ______ Date of Birth ______ SS # ______

Employer ______ City ______ State ______ Zip ______ Phone ______

Insurance Company ______ Group # ______

Ins. Address ______ City ______ State ______ Zip ______

Father's Name ______ Mother's Name ______

D.O.B. ______ SS # ______ D.O.B. ______ SS # ______

Employer ______ Employer ______

Occupation ______ Occupation ______

Business Address ______ Business Address ______

Work Phone ______ Work Phone ______

Marital Status: Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐

In case of emergency, contact: ______ Phone ______

List names and ages of brothers and sisters of patient: ______

______

Whom may we thank for refering your child to us? Not referred how did you hear about us? ______

Has your child seen any other Pediatric Dentist? If so, who? ______

In the event we are unable to contact you personally, please initial giving us consent to leave a message on your answering machine regarding your child's diagnostic results. Yes ☐ No ☐ ______ (Initial)

PATIENT HEALTH RECORD

Does your child have regular medical checkups? Yes ☐ No ☐ Last physical exam ______

Child's Physician: Name ______ Phone ______

Address ______

Does your child have a current medical problem? ______

If Yes, Explain: ______ Any current medication? ______ Dosage ______

What is your child's best method of taking medication? ______

Is your child allergic to: Penicillin ☐ Antibiotics ☐ Novocaine ☐ Aspirin ☐ ______

Foods ______ Others ______

______

Has your child ever been hopitalized? Yes ☐ No ☐ When ______

Significant injuries ______

Answering these questions accurately can help us better assess your child's risk of dental disease.

Does your child have sugar? .... Yes ☐ No ☐ How often? ______

Does your child drink juice, soda, gatorade? .... Yes ☐ No ☐

Does your child eat chips, crackers, goldfish, pretzels? .... Yes ☐ No ☐

Do you brush your child's teeth after snacking? .... Yes ☐ No ☐

Does your child chew any gum / mints containing xylitol? .... Yes ☐ No ☐

Does your child use any mouth rinse products? .... Yes ☐ No ☐

Does your child use flouridated toothpaste? .... Yes ☐ No ☐

Does your child drink flouridated water? .... Yes ☐ No ☐

Has your child ever had any of the following: Please ☒ and explain below:

☐ Heart trouble	☐ Diabetes	☐ Asthma	☐ Congenital Birth Defects	☐ Seizures
☐ Tuberculosis	☐ Kidney problems	☐ Liver Disease	☐ Headaches	☐ Behavioral problems
☐ Epilepsy	☐ Cleft lip or palate	☐ Speech difficulty	☐ Blood transfusions	☐ Endocrine problems
☐ Bleeding problems	☐ Blood disorder	☐ Lung problems	☐ Blood Dyscrasias	☐ Mental developmental delays
☐ Emotional problems	☐ Jaundice	☐ Cerebral palsy	☐ Cancer / Tumors	☐ Frequent infections
☐ HIV	☐ Hearing problems	☐ Sight problems	☐ Physical Develop. Delays	☐ Autism

☐ Others ______

Explain ______

Has your child previously been to the dentist? Yes ☐ No ☐ if so,whom? ______

Were there any problems? ______

Has your child ever had any injuries to their teeth? Yes ☐ No ☐

Explain circumstance and when occurred ______

Has your child ever had any of the following: Please ☒ and explain below:

☐ Thumb Sucking	☐ Finger sucking	☐ Grinding teeth	☐ Lip sucking
☐ Lip biting	☐ Nail biting	☐ Sleeping with mouth open	

Explain ______

Reason for dental visits ______

Are there any dental problems bothering your child at this time? Yes ☐ No ☐ Explain ______

Additional Comments: ______

______

I authorize Dr. D.P. Trupkin, Dr. A.T. Wilentz, Dr. J.P. Hirsch, or any other dentist in the office to treat the above-mentioned patient using restorative or oral surgery techniques as well as patient management techniques that are reasonable and necessary as deemed advisable. I understand that the treatment plan presented, along with the fees outlined, could change depending upon the time elapsed since the examination and the extent of decay. I also agree to pay all charges NOT covered by insurance, state agency, etc. I also acknowledge that I will be responsible for any and all collection fees if this account goes into a delinquent state.

______ RELATIONSHIP TO PATIENT

______ SIGNED

______ DATE

THANK YOU FOR HELPING US LEARN MORE ABOUT YOUR CHILD.