# Tualatin Pediatric Dentistry

18803 SW Boones Ferry Road Suite #5 Tualatin, Oregon 97062-1847
Phone: (503) 692-3747 Fax: 612-6948

Child's Name_____Nickname_____Sex_____
FIRST MIDDLE LAST
Age_____Birthdate_____Place of Birth_____
School_____Grade_____

Explain briefly why you brought your child in for dental care if other than a regular check up _____
_____

**CHILD'S HEALTH HISTORY-** In order to render the best possible care for your child, your assistance is needed in answering the following questions.

1) Is this your child's first visit to the dentist? YES NO
If no, when was your child last seen?_____ Were x-rays taken? YES NO

2) Is your child in good health? YES NO
If no please explain_____

3) Was your child born premature? YES NO How many weeks?_____

4) Has your child had any hospitalizations or surgeries? YES NO
If so please specify_____

5) Has anyone in your family had a negative reaction to general or local anesthetic? YES NO
If yes please explain_____

6) Is your child sensitive or allergic to any medication? YES NO
If so please specify_____ Does your child have a latex allergy? YES NO

7) Are your child's immunizations current? YES NO

8) Is your child taking any medication(s) at this time? YES NO
If so please specify_____

9) Is your child receiving daily fluoride from: __TABLETS __WATER __ TOOTHPASTE __NONE

10) Does your child or has your child ever had one of the following:

| | | | |
|---|---|---|---|
| __HEART CONDITION | __MEDICATION ALLERGY | __DIABETES | __ASTHMA/LUNG PROBLEMS |
| __SEIZURES | __TUBERCULOSIS | __ANEMIA | __NERVOUSNESS |
| __RHEUMATIC FEVER | __KIDNEY PROBLEMS | __HEPATITIS | __LIVER PROBLEMS |
| __HIV+/AIDS | __BLEEDING DISORDERS | __CANCER | __BEHAVIORAL PROBLEMS |

PLEASE SPECIFY/EXPLAIN IF CHECKED ABOVE: _____

12) Has your child seen an orthodontist? _____ Orthodontist Name:_____

13) Your child's physician or pediatrician? _____
Clinic Name _____ Phone _____

*I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any changes to my child's health or medication.*

Signature of Parent/Guardian_____ Date_____