Franziska K. Dutton DDS

Confidential CHILD Medical Health Information

(Please Print Legibly)

Patient Name:_____ Birthdate: _____ Age: _____

☐ Parent ☐ Guardian Name: _____ Relationship: _____

Emergency Contact: Name:_____ Relationship: _____

Phone: Home:_____ Work: _____ Mobile: _____

Physician Name_____ Phone: _____

Physician Address: _____

Please √ ☐ Yes or ☐ No below:

Yes	No		
☐	☐	Physician care at present?	Describe: _____
☐	☐	Medical Condition?	Describe: _____
☐	☐	Congenital Heart Disease (excluding Mitral Valve Prolapse)	
☐	☐	Hospitalized ever?	Describe: _____
☐	☐	Surgeries (type and date): _____	
☐	☐	Other Important Information: _____	

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOUR CHILD HAS OR HAD:

A. AIDS/HIV+	F. Epilepsy	K. Jaundice	P. Sexually Transmitted Disease
B. Arthritis	G. Glaucoma	L. Kidney Problems	Q. Stroke
C. Asthma	H. Hepatitis: Type____	M. Liver Problems	R. Tuberculosis
D. Cancer*	I. Heart Problem*	N. Low Blood Pressure	S. Childhood Diseases*
E. Diabetes: Type ____	J. High Blood Pressure	O. Respiratory Disease	T. Other Diseases*

* Comments:_____

ALLERGIES (Medicine, drug, other)

List: _____

MEDICATIONS (Including Herbal Supplements)

Medicine	Dose/Frequency	Medical Condition	Pharm (DDS to complete)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Attach separate list of medications if more than 4 taken

(Please turn over and complete the back side of this form.)

********** ***Office use only*** **********

VITAL SIGNS

Heart rate: _____BPM

Blood Pressure: _____mmHg

O_2 Saturation: _____%

ALTERATIONS TO PATIENT CARE

_____

_____

_____

PROPHY ANTIBIOTICS NEEDED? ☐ **YES** ☐ **NO**

If Yes, type:_____

MD consult prior to dental tx? ☐ **YES** ☐ **NO**

Who will prescribe? ☐ **MD** ☐ **DDS**

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CHILD Dental Health Information

Is this your child's first dental visit? ☐ YES ☐ NO Age at first dental visit: _____ years

Previous Dentist: Name:_____ Date of last visit: _____
Address: _____ Phone Number: _____

Is your child fearful of dental treatment? ☐ YES ☐ NO Describe: _____
Would you like your child to have Flouride supplement prescription? ☐ YES ☐ NO

How did you hear about our office? _____
Reason for dental visit? _____

Yes	No	**Has your child had…**
☐	☐	Regular Preventive Dental Visits?
☐	☐	Dental Sealants?
☐	☐	X-rays taken?
☐	☐	Fluoride Treatments?
☐	☐	Dental Sedation?
☐	☐	Nitrous Oxide Gas?
☐	☐	Local anesthetic?
☐	☐	Adverse reaction to anesthetic? Describe:_____

Yes	No	**Child have a history of…**
☐	☐	Dental Decay?
☐	☐	Thumb sucking?
☐	☐	Mouth breathing?
☐	☐	Teeth Grinding?
☐	☐	Jaw Clenching?
☐	☐	Dental injury or facial trauma? Describe:_____

Yes	No	**Child have sensitivity to…**
☐	☐	Heat?
☐	☐	Cold?
☐	☐	Sweets?
☐	☐	Biting Pressure?
☐	☐	Chewing?
☐	☐	Other? Describe:_____

Parent/Guardian Signature:_____ Date:_____

Dentist Signature:_____ Date:_____ Staff Initials: _____