kidSMILES
PEDIATRIC DENTAL CLINIC

PATIENT MEDICAL/DENTAL HISTORY AND GENERAL INFORMATION FORM

CHILD / PATIENT INFORMATION		
CHILD'S LAST NAME:	FIRST NAME:	MIDDLE NAME:
BIRTH DATE:	AGE:	SEX: MALE OR FEMALE
HOME ADDRESS:		

PARENT / LEGAL GUARDIAN INFORMATION		
MOTHER'S LAST NAME:	FIRST NAME:	MIDDLE NAME:
HOME ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
FATHER'S LAST NAME:	FIRST NAME:	MIDDLE NAME:
HOME ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:
LEGAL GUARDIAN LAST NAME*(If other than parent only)*:		
HOME ADDRESS:		
HOME PHONE:	CELL PHONE:	WORK PHONE:

MEDICAL HISTORY					
Do you consider your child to be healthy?	YES ☐	NO ☐	Is your child now taking any drugs or medicine?	YES ☐	NO ☐
Has your child ever been hospitalized?	YES ☐	NO ☐	If yes, please list:		
Has your child ever had a bad reaction to medication?	YES ☐	NO ☐	Does your child have allergies?	YES ☐	NO ☐
Has your child ever had penicillin?	YES ☐	NO ☐	If yes, please list:		

Has your child ever had any of the following? Please check yes or no for each.					
Anemia	YES ☐	NO ☐	Heart attack	YES ☐	NO ☐
Arthritis	YES ☐	NO ☐	Heart problems or murmur	YES ☐	NO ☐
Asthma	YES ☐	NO ☐	Hepatitis or liver disease	YES ☐	NO ☐
Autism	YES ☐	NO ☐	Herpes	YES ☐	NO ☐
Birth defects or genetic disorders	YES ☐	NO ☐	High blood pressure	YES ☐	NO ☐
Bleeding disorder	YES ☐	NO ☐	HIV/AIDS	YES ☐	NO ☐
Bone or joint problems	YES ☐	NO ☐	Kidney disease	YES ☐	NO ☐
Cancer	YES ☐	NO ☐	Rheumatic fever	YES ☐	NO ☐
Cerebral palsy	YES ☐	NO ☐	Sexually transmitted disease	YES ☐	NO ☐
Chest pains	YES ☐	NO ☐	Sickle cell anemia or trait	YES ☐	NO ☐
Cleft lip or palate	YES ☐	NO ☐	Smoking, use of snuff or smokeless tobacco	YES ☐	NO ☐
Developmental disabilities	YES ☐	NO ☐	Speech difficulties	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐	Stroke	YES ☐	NO ☐
Drug or alcohol use	YES ☐	NO ☐	Syphilis	YES ☐	NO ☐
Ear or hearing problems	YES ☐	NO ☐	Thyroid problems	YES ☐	NO ☐
Epilepsy	YES ☐	NO ☐	Tuberculosis or any lung disease	YES ☐	NO ☐
Glaucoma	YES ☐	NO ☐	Vision problems	YES ☐	NO ☐

DENTAL HISTORY

Has your child ever had any of the following (please check all that apply):

☐ Abscesses (gum boils) ☐ Bad breath ☐ Bleeding gums ☐ Cold sores *(fever blisters)*

☐ Finger or thumb sucking ☐ Frequent sore throat ☐ Injury to front teeth ☐ Stained teeth

☐ Teeth grinding or clenching ☐ Toothaches

Is this your child's first visit to the dentist?	☐ YES	☐ NO	Comments:
Does your child have a toothache or other dental problems now?	☐ YES	☐ NO	Comments:
Has your child ever had a bad experience in a dental office?	☐ YES	☐ NO	Comments:
Has your child ever had local anesthetic (Novocain, Lidocaine)?	☐ YES	☐ NO	Comments:
Do you think your child will be a cooperative patient?	☐ YES	☐ NO	Comments:
Has your child had a dental checkup within two years?	☐ YES	☐ NO	Comments:
If yes, please provide the name and address of patient's dentist:			
Date of last visit:			
Has your child had dental x-rays within the past year?	☐ YES	☐ NO	Comments:

HOUSEHOLD INFORMATION *(this box most be completed)*

Approximate Annual Household Income:

Number of adults in the home:	Number of children in the home:

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaskan Native

☐ Other_____

If you have recently moved here from another country, please tell us where you are from:_____

What language are you and your child most comfortable speaking:_____

SIGNATURES

Parent/Guardian Signature:	
Parent/Guardian Printed Name:	Date:
Dentist Signature:	
Dentist Printed Name:	Date:

REFERRAL INFORMATION

How did you hear about KidSMILES Pediatric Dental Clinic?

☐ Word of mouth/Friend ☐ TV/Radio ☐ Newspaper ☐ School Nurse (name of school)_____

☐ Head Start _____ (name of school) ☐ Other_____