

RISING STARS PEDIATRIC DENTISTRY

Medical History/Patient Information Update

Child's Name _____ Preferred Name: _____ Age: _____

Parent's phone number: HOME _____ WORK _____ CELL _____

Primary Care Doctor/Pediatrician Name _____ Date of last **Medical** examination _____

1. Has your child had any dental trauma since their last Dental visit? YES or NO
• Did they see a Dentist for this trauma? YES or NO
• If so who? _____ When? _____

2. Has your child had or does he/she now have?
• Latex Allergy YES or NO Seasonal Allergies YES or NO
• Food Allergies _____
• Drug Allergies _____

3. Has your child had any history of asthma or breathing problems? _____
• Has your child been to the ER for an asthma attack? _____
• What induces the breathing problems? _____
• What asthma medication does your child take? _____

4. Please answer the following questions:

4. Autism Spectrum	Yes No	15. Hearing/Vision Impairment	Yes No	26. Prolonged Bleeding /Transfusions	Yes No
5. Sensory Integration Issues	Yes No	16. Eating disorders	Yes No	27. Steroids therapy or chemotherapy	Yes No
6. ADD/ADHD	Yes No	17. Abnormal Bleeding or bruising	Yes No	28. Nervous or emotional disorders	Yes No
7. Heart Trouble or heart murmur	Yes No	18. Problems with Anesthesia	Yes No	29. Thyroid disease	Yes No
8. Rheumatic heart disease/fever	Yes No	19. Birth Defects	Yes No	30. Frequent diarrhea or vomiting	Yes No
9. Blood diseases or anemia	Yes No	20. Kidney Disease	Yes No	31. Mumps, measles, or chickenpox	Yes No
10. AIDS virus	Yes No	21. Cleft lip or palate	Yes No	32. Cancer, tumors, growths or cysts	Yes No
11. Herpes virus or shingles	Yes No	22. Scarlet fever or high fever	Yes No	33. Sinus problems or drainage	Yes No
12. Diabetes	Yes No	23. High or low blood pressure	Yes No	34. Tuberculosis or TB exposure	Yes No
13. Ear, eye, nose or throat trouble	Yes No	24. Liver disease	Yes No	35. Convulsions or Seizures	Yes No
14. Stomach ulcers	Yes No	25. Jaundice or hepatitis	Yes No	36. Date of last seizure _____	

If you answered "YES" to any above items, please explain: _____

CURRENT MEDICATIONS:

<u>Name/Strength (mg)</u>	<u>How often?</u>	<u>Reason taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. How often does your child brush? _____ Electric toothbrush? YES / NO

How often does your child floss? DAILY / SOMETIMES / NEVER

Has your home address/phone changed? YES/NO

If so, please fill out the following:

Address/City/Zip: _____

Home Phone # _____ Work # _____ Cell#: _____

Email Address: _____

Has your dental insurance changed? YES/NO

If so, please fill out the following and/or allow us to see your card:

Insured Name _____ SSN/ID _____

DOB _____ Relationship to child _____

Place of Employment _____

Work Phone # _____ Occupation: _____

Name of Dental Carrier _____ Group# _____

Mailing Address for Dental Claims: _____

Phone _____

Parent's Signature _____ Date _____