Children's Dentistry Group, LLC

Sarah A. Mahmoud, D.M.D.
Paul D. Herer, D.M.D., M.S.
Melissa J. Patenio, D.D.S., M.S.
Anupama Krishnamurthy, D.D.S.
Dhwani M. Joshi, D.M.D.

CONFIDENTIAL HEALTH HISTORY FORM

Please fill out all applicable information completely.

Patient's Name: _____ Nickname: _____ Birthdate: _____

Residence/Street: _____ Home Phone: _____ Sex: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

Father's Name: _____ Employer: _____ SS#: _____

Cell Phone: _____ Work Phone: _____ Birthdate: _____ Marital Status: S / M / D / W

Mother's Name: _____ Employer: _____ SS#: _____

Cell Phone: _____ Work Phone: _____ Birthdate: _____ Marital Status: S / M / D / W

Elect to receive quarterly newsletter? Yes No (Please circle) Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Address: _____ Date of Last Medical Exam: _____

Are your child's immunizations up to date? □ Yes □ No Is your child currently taking any medications? □ Yes □ No

Medications: (Please include dose & frequency) _____

Significant injuries (such as head or teeth, broken bone, car accidents)? Please describe: _____

_____Height: _____ Weight: _____

DOES THE PATIENT HAVE OR HAD ANY OF THE FOLLOWING?
Please indicate with an (X)

- ☐ Allergies (skin rashes, medication, food, dust, other _____)
- ☐ Anemia or blood problems (Sickle Cell)
- ☐ Arthritis/Joint pain
- ☐ Asthma/Breathing problems
- ☐ Bleeding problems
- ☐ Bone or Muscular problems
- ☐ Bronchitis
- ☐ Cancer/other tumors
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Ear/Hearing
- ☐ Endocrine/Glandular problems
- ☐ Eye/Vision problems
- ☐ Handicaps (mental, physical, emotional)
- ☐ Heart defects
- ☐ Hepatitis/Jaundice
- ☐ Immuno Suppressive (A.I.D.S.) Disease
- ☐ ***Hospitalizations***:_____ _____
- ☐ Kidney/Urinary Tract problems
- ☐ Learning Disorders_____
- ☐ Measles
- ☐ Mumps
- ☐ Nervous/Seizure problems
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Radiation Treatments
- ☐ Scarlet Fever
- ☐ Stomach/Digestive problems
- ☐ Venereal Disease

DENTAL HISTORY

Current Dentist's Name: _____Phone: _____

Address: _____Date of Last Dental Exam: _____

Has the patient had any unfavorable dental experiences? **YES NO** If yes, please explain: _____

Chief Oral Complaint: _____

DOES THE PATIENT HAVE OF USE ANY OF THE FOLLOWING?
Please indicate with an (X)

- ☐ Traumatic injury to mouth or teeth
- ☐ Sensitivity to cold/hot/sweet/pressure
- ☐ Bleeding gums? How long_____
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around the ears
- ☐ Bad Breath
- ☐ Complications from extractions
- ☐ Topical Fluoride Treatment
- ☐ Orthodontic Treatment or Supplements
- ☐ Mouth breathing
- ☐ Bedtime nursing bottle
- ☐ Toothbrush texture_____
- ☐ Brushing frequency _____
- ☐ Dental Floss frequency _____
- ☐ Disclosing tablets/solutions
- ☐ Between meal snacks
- ☐ Well-balanced diet
- ☐ Oral habits: thumb sucking, nail biting, pacifier, cheek biting, tongue thrusting

Describe any current medical treatment including drugs taken, even though not listed above:

_____

_____

Is there anything that you feel Children's Dentistry Group should know about the patient?

_____

I certify that I have read and understand the above question. I will not hold Children's Dentistry Group, LLC responsible for any errors or omissions I may have made in completion of this form.

Signature of Person Completing Form: _____

Relationship to Patient: _____ **Date:** _____