



DR. BETH COOK

Pediatric Dentistry of South Charlotte

Specializing in dental care for
infants, children and adolescents

New Patient Medical and Dental History

Welcome to our office! Careful completion of this form will assist us in providing your child with the best possible dental care.

Child's Name _____ Today's Date ___/___/_____

Name and phone number of child's primary care physician _____

Is your child under the care of any specialist physician? [] Yes [] No

If so, please state name and specialty _____

When was your child's last medical check-up? _____

Are all immunizations current? [] Yes [] No

Is your child allergic to anything? (e.g. Medications, Latex, Foods) [] Yes [] No

If so, what? _____

Is your child taking any medications at this time? [] Yes [] No

If so, what? _____

Has your child ever been hospitalized? [] Yes [] No

If so, what for? _____

Has your child ever had surgery or general anesthesia? [] Yes [] No

If so, what for and were there any complications? _____

Has your child ever been diagnosed as having any of the following conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Congenital Birth Defects | <input type="checkbox"/> Nutritional Deficiency |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fainting | <input type="checkbox"/> Respiratory Syncytial Virus |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sickle Cell Anemia/Trait |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Heart condition/Heart murmur | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Syndrome _____ |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney/Liver Problems | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Other _____ |

Is this your child's first visit to the dentist? [] Yes [] No

If not, how long since the last visit to the dentist? _____ Were x-rays taken? [] Yes [] No

Previous dentist's name? _____

Has your child ever had any injuries to the teeth, face or mouth? [] Yes [] No

If yes, please explain _____

Does your child have any of the following habits?

Thumb/finger sucking [] Yes [] No Lip Sucking/Biting [] Yes [] No Nail Biting [] Yes [] No

Does your child nurse or take a bottle? [] Yes [] No

How often are child's teeth brushed? _____ How often are they flossed? _____

Is your child's water fluoridated? [] Yes [] No Is the child receiving fluoride supplements? [] Yes [] No

Has your child ever had a serious or difficult problem associated with previous dental work? [] Yes [] No

If yes, please explain _____

What is your reason for bringing your child to the dentist today? _____

How do you think your child will react today? (e.g. Shy, anxious, cooperative, defiant) _____

Is there anything else you think we should know about your child? _____

Name _____ **Signature** _____