DEVON
PEDIATRIC DENTISTRY

Patient Name: _____

Address: _____

_____

Phone Numbers: _____

E-mail Address: _____

Preferred Method of Communication
(Please check one)

❑ E-mail ❑ Text ❑ Phone

Insurance Carrier: _____

Date of last physician visit: _____

Medical/Dental History Update

Is your child being treated by a physician at this time?.....❑ Y ❑ N
Reason: _____
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?.....❑ Y ❑ N
List name, dose, frequency, & date started: _____
Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year?.....❑ Y ❑ N
Has your child ever had a reaction to or problem with an anesthetic?.....❑ Y ❑ N
Describe: _____
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication?.....❑ Y ❑ N
Is your child allergic to latex or anything else such as metals, acrylic, or dye?.....❑ Y ❑ N
List: _____
Have there recently been any significant changes/disruptions to your child's family, home, or school routines?.....❑ Y ❑ N
List: _____
What is your primary concern regarding your child's oral health? _____
Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? ❑ Y ❑ N
Describe: _____
Has your child's diet changed significantly since his/her last dental visit?.....❑ Y ❑ N
Describe: _____
Has your child been treated by another dentist/dental professional since last visiting our office? ❑ Y ❑ N
Describe: _____
Is there any other change in the child's medical, dental, or family history that the dentist should be told?.....❑ Y ❑ N
Describe: _____
Has your child travelled outside of the United States in the last month?.....❑ Y ❑ N
If so, where: _____

Signature of parent/guardian: _____
Relationship to child: _____ Date: _____