BOUDREAU FAMILY DENTAL
SMILE CARE FOR LIFE

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CHILD PATIENT - MEDICAL AND DENTAL HISTORY

Your child's overall health, habits, and any medications which your child takes could have an important interrelationship with the dental care we provide. Please answer each of the following questions completely.

How often does your child brush?

How often does your child floss?

Is your child's water fluoridated? ❑ Yes ❑ No

Does your child take fluoride supplements? ❑ Yes ❑ No

Does your child:

- Suck Thumb/ Finger ❑ Yes ❑ No
- Suck/ Bite Lip ❑ Yes ❑ No
- Bite/ Chew Nails ❑ Yes ❑ No
- Chew Hard Objects (pencils, etc.) ❑ Yes ❑ No
- Grind Teeth ❑ Yes ❑ No
- Clench Jaws ❑ Yes ❑ No

Has your child had difficulty with previous dental visits? ❑ Yes ❑ No

Has your child ever taken Fen-Phen/Redux? ❑ Yes ❑ No

Child's Previous Dentist:

Address:

Date of Last Dental Visit:

Has your child ever had any of the following:

Asthma	❑ Yes	❑ No
Handicaps / Disabilities	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
HIV / AIDS	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No
Congenital Heart Defect	❑ Yes	❑ No
Abnormal Bleeding	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Convulsions / Epilepsy	❑ Yes	❑ No
Stomach, Liver or Kidney problems	❑ Yes	❑ No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑ Yes	❑ No

Child's Physician: Phone:

Address: City: State: ZipCode:

Previous Hospitalizations / Surgeries / Serious Illnesses: *When?*

Is your child taking any medication? ❑ Yes ❑ No *if yes, please list:*

Does your child have a history of allergies / sensitivities / adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ❑ Yes ❑ No *if yes, please explain:*

Does your child have a history of allergies to any other substances (latex, environmental, etc.) ❑ Yes ❑ No *if yes, please explain:*

Does your child have any other medical issues? ❑ Yes ❑ No *if yes, please explain:*

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Phone:_____

Signature of Parent or Guardian of Patient