Access Dental | Blue Hills DENTAL

PATIENT NAME________________________________

CHILD'S DENTAL & MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete both sides of this dental & medical history form.

Has your child had the following disease or problems? **Active Tuberculosis** ☐ YES ☐ NO **Cough that produces blood** ☐ YES ☐ NO
IF YOU ANSWER YES TO EITHER OF THE QUESTIONS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.

Is this your child's first dental visit? ☐ YES ☐ NO

If NO, date of last dental visit____________ Last dental cleaning____________ Last full-mouth X-rays____________

Has your child had difficulty with previous dental visits? ☐ NO ☐ YES If yes, please describe____________

Has your child ever worn orthodontic appliances? ☐ NO ☐ YES If yes, please describe____________

How often does your child brush?____________ How often does your child floss?____________ Do you assist your child? ☐ YES ☐ NO

Is your child's water fluoridated? ☐ YES ☐ NO Does your child take fluoride supplements? ☐ YES ☐ NO

Are your child's teeth...?

	YES	NO		YES	NO		YES	NO
Sensitive to Hot or Cold?	☐	☐	Sensitive to Sweets?	☐	☐	Sensitive to Biting or Chewing?	☐	☐

Does your child engage in...?

	YES	NO		YES	NO
Thumb or finger sucking?	☐	☐	Chewing or biting fingernails?	☐	☐
Biting or sucking lips or cheeks?	☐	☐	Chewing hard objects (i.e., pencils)?	☐	☐
Grinding teeth?	☐	☐	Jaw clenching?	☐	☐
Mouth breathing?	☐	☐	Bottle nursing or pacifier habits?	☐	☐

Do your child's gums hurt or bleed? ☐ YES ☐ NO
Does your child have any pain or tenderness in the jaw joint, ear, or side of face? ☐ YES ☐ NO
Does your child have a health problem? ☐ YES ☐ NO
If yes, please describe____________
Is your child under the care of a physician? ☐ YES ☐ NO
If yes, please describe____________
Is your child taking any medications? ☐ YES ☐ NO
If yes, please describe____________
Has your child had any serious illnesses, hospitalizations or surgeries? ☐ YES ☐ NO
If yes, please describe____________
Has a doctor told that your child needs antibiotics or pre-medications before dental treatment? ☐ YES ☐ NO
Does your child have any allergies or adverse reactions to any medication or other substance(s)? ☐ YES ☐ NO
If yes, please describe____________
Are your child's immunizations current? ☐ YES ☐ NO

Indicate which of the following your child has had or has at present. Check "YES" or "NO" to each item.

	YES	NO		YES	NO		YES	NO
A.D.D./A.D.H.D.	☐	☐	Cold Sores/Fever Blisters	☐	☐	Lung Problem or Disease	☐	☐
A.I.D.S./H.I.V. Positive	☐	☐	Congenital Heart Disease	☐	☐	Measles/Mumps	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Mononucleosis	☐	☐
Asthma	☐	☐	Epilepsy or Seizures	☐	☐	Neurological Disorders	☐	☐
Asperger's or Autism	☐	☐	Hay Fever/Allergy/Hives	☐	☐	Psychiatric/Psychological Care	☐	☐
Blood Disease or Bleeding Disorder	☐	☐	Head Injury	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Blood Transfusion	☐	☐	Hearing Impairment	☐	☐	Sickle Cell Anemia	☐	☐
Brain Injury	☐	☐	Heart Condition	☐	☐	Stomach Problem	☐	☐
Cancer, Tumors, Growths	☐	☐	Heart Murmur	☐	☐	Tonsillitis	☐	☐
Cerebral Palsy	☐	☐	Hepatitis A B C (CIRCLE WHICH ONE)	☐	☐	Tuberculosis	☐	☐
Chemotherapy or Radiation Therapy	☐	☐	Kidney Infection or Disease	☐	☐	Other (Please list below)	☐	☐
Chicken Pox	☐	☐	Latex Allergy or Sensitivity	☐	☐	____________		

I understand that the above information is necessary to provide my child dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Access Dental/Blue Hills Dental has my permission to ask my respective health care provider or agency to release such information to Access Dental/Blue Hills Dental. I will notify the dentist of any change in my child's health.

PARENT/GUARDIAN SIGNATURE ____________ DATE ____________ DENTIST REVIEW SIGNATURE *(NON-EHR)* DATE ____________

HISTORY REVIEW DATE ____ /____ /______

PARENT: Any changes to your child's health?
☐ NO ☐ YES – If yes, describe changes below
____

DENTIST: Patient history reviewed.
____
SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE ____ /____ /______

PARENT: Any changes to your child's health?
☐ NO ☐ YES – If yes, describe changes below
____

DENTIST: Patient history reviewed.
____
SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE ____ /____ /______

PARENT: Any changes to your child's health?
☐ NO ☐ YES – If yes, describe changes below
____

DENTIST: Patient history reviewed.
____
SIGNATURE *(NON-EHR)* DATE

AUTHORIZATION FOR AGENT TO CONSENT TO DENTAL TREATMENT OF MINOR IN ABSENCE OF PARENT

I, ________________________________, am the parent, legal guardian or authorized caregiver of ________________________________.
FULL NAME OF PARENT FULL NAME OF CHILD PATIENT

I hereby, in my absence at Access Dental/Blue Hills Dental, give full authorization to ________________________________ to:
FULL NAME OF AUTHORIZED AGENT

- ☐ provide transportation for my child to his/her dental appointment at Access Dental/Blue Hills Dental.
- ☐ sign any consent form that may be required by the Dentist and/or Access Dental that are necessary to render any and all necessary treatment for my child.
- ☐ consent to any X-ray, examination, anesthetic, dental diagnosis or treatment of my child deemed advisable by a dentist or hygienist and provided by that dentist or hygienist or under that dentist's or hygienist's supervision.

In the event of an emergency during the appointment, or while the child is on Access Dental/Blue Hills Dental property, said individual has the authority to make decisions on my behalf.

I assume full responsibility for any error(s) of commission or omission arising from the decisions made on my behalf by the aforementioned individual.

This authorization is made under California Family Code §6910.

PARENT/GUARDIAN SIGNATURE DATE

WITNESS SIGNATURE DATE