Medical History – Child Patient

Date Created:

CROWLEY DENTAL CARE

Patient Name: **Date of Birth:**

Email: **Parent Phone Number:**

Who referred you to our office?

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions.

Is your child under a physician's care now? ☐ Yes ☐ No

Does your child have a primary care physician? ☐ Yes ☐ No

If yes, please list name and contact information:

Has your child ever been hospitalized or had? a major operation? If yes, please explain: ☐ Yes ☐ No

Has your child ever had a serious head or neck injury? ☐ Yes ☐ No

Is your taking any medications, pills, or drugs? ☐ Yes ☐ No

If yes, please list:

How often does your child brush?

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

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

If yes, please explain:

Does your child have any of the following habits?

Suck thumb/finger	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Chew hard objects (pencils,etc.)	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No

Is your child allergic to any of these? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other Allergies? ☐ Yes ☐ No If yes, please list:

Do you have, or have you had any of the following? Please check **YES (Y)** or **NO (N)**.

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Anaphylaxis	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Anemia	☐	☐	Drug Addiction	☐	☐	High Cholesterol	☐	☐	Sickle Cell Disease	☐	☐
Angina	☐	☐	Epilepsy or Seizures	☐	☐	Hives or Rash	☐	☐	Sinus Trouble	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hypoglycemia	☐	☐	Spina Bifida	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Irregular Heartbeat	☐	☐	Stomach/Intestinal Disease	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Kidney Problems	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Swelling of Limbs	☐	☐
Blood Transfusion	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Thyroid Disease	☐	☐
Breathing Problems	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Bruise Easily	☐	☐	Hay Fever	☐	☐	Lung Disease	☐	☐	Tumors or Growths	☐	☐
Cancer	☐	☐	Heart Attack/Failure	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers	☐	☐
Chemotherapy	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐			
Chest Pains	☐	☐	Heart Pacemaker	☐	☐	Radiation Treatments	☐	☐			
Cold Sores/Fever Blisters	☐	☐	Hemophilia	☐	☐	Recent Weight Loss	☐	☐			
Congenital Heart Disorder	☐	☐	Hepatitis A, B or C	☐	☐	Renal Dialysis	☐	☐			

If yes, please explain:

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:

New Patient Registration

CROWLEY
DENTAL CARE

First Name: **Middle Initial:**

Last Name: Patient Is: ○ Policy Holder ○ Responsible Party

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

Full Name: Email:

Address: Home: ( )

Work: ( )

City: State: Zip: Mobile: ( )

Birth Date: SSN:

I am: ○ Policy holder for the patient ○ Primary insurance policy holder ○ Secondary insurance policy holder

PATIENT INFORMATION AGE ○ MALE ○ FEMALE

Address: Email:

Home: ( )

City: State: Zip: Work: ( )

Birth Date: SSN: Mobile: ( )

☐ I would like to receive correspondences via email.

Employment: ○ Full Time ○ Part Time ○ Retired **Student:** ○ Full Time ○ Part Time

Employer:

PRIMARY INSURANCE RELATIONSHIP TO INSURED ○ SELF ○ SPOUSE ○ CHILD ○ OTHER

Name of Insured:	Insurance ID: Insurance Group ID:
Insured Social Security:	Insured Birth Date:
Employer:	Insurance Company:
Address:	Address:
City: State: Zip:	City: State: Zip:
Employer Phone:	Insurance Phone:

SECONDARY INSURANCE RELATIONSHIP TO INSURED ○ SELF ○ SPOUSE ○ CHILD ○ OTHER

Name of Insured:	Insurance ID: Insurance Group ID:
Insured Soc. Sec:	Insured Birth Date:
Employer:	Insurance Company:
Address:	Address:
City: State: Zip:	City: State: Zip:
Employer Phone:	Insurance Phone: