

Pediatric Patient Information and Health History Form

175 Littleton Road
Westford, MA 01886
(978) 392-9800



80 High Street
Medford, MA 02155
(781) 391-8300

Careful completion of this form will assist us in providing your child with the best possible care.

Child's Name _____ Nickname _____ Sex: M F D.O.B. _____

Mailing Address Street _____ Home Phone _____

City _____ State _____ Zip _____

Phone Number to reach Mother/Father during the day _____

Names and Ages of Siblings _____

Who may we thank for referring you? Parent's Name _____ Child's Name _____

Address _____

City, State, Zip _____

PARENTAL INFORMATION

FATHER

MOTHER

Name _____

Date of Birth _____

Home Address: Street _____

City, State, Zip _____

Telephone Number _____

Cell _____

Email _____

Occupation _____

Name of Employer _____

Street _____

City, State, Zip _____

Business Phone _____

Social Security Number _____

Marital Status: Married Single Separated Divorced Widowed

DENTAL INSURANCE

Name of Carrier _____

Policy Number _____ Father's Plan Mother's Plan

Carrier Address _____

Carrier Phone Number _____

Name of Carrier _____

Policy Number _____ Father's Plan Mother's Plan

Carrier Address _____

Carrier Phone Number _____

I hereby authorize payment directly to Robert A. Frank, D.M.D., Peter B. Geller, D.D.S., P.C.,
the dental benefits otherwise payable to me.

SIGNED (Insured Person)

DATE

MEDICAL HISTORY

Child's Physician _____ Phone # _____

Address _____ City, State, Zip _____

Date of Last Physical Examination _____

Is your child being treated by a physician at this time? YES NO

If yes, why? _____

Is your child taking any medications at this time?..... YES NO

If yes, what and why? _____

Has your child ever been hospitalized? YES NO

If yes, why and when? _____

Has your child ever had any operations? YES NO

If yes, why and when? _____

Has your child ever had a blood transfusion? YES NO

If yes, why and when? _____

Has your child ever had general anesthesia? YES NO

If yes, were there any complications? _____

Is your child allergic to anything? (Medications, Food)..... YES NO

If yes, what? _____

Has your child ever been given penicillin?..... YES NO

If yes, were there any complications? _____

Is your child up to date on his/her immunizations?..... YES NO

ORGANS AND SYSTEMS: Has your child ever had any treatment for any of the following? Please check yes or no:

YES	NO		YES	NO	
_____	_____	Blood – Circulatory/ Transfusions	_____	_____	Heart
_____	_____	Bones	_____	_____	Liver
_____	_____	Endocrine Glands	_____	_____	Muscles
_____	_____	Eyes, Ears, Nose, Throat	_____	_____	Nervous System
_____	_____	Gastrointestinal (stomach)	_____	_____	Skin Eczema
_____	_____	Kidney – Bladder	_____	_____	Tonsils/Adenoids
_____	_____	Lungs			

If yes to any of the above, please elaborate: _____

ILLNESS: Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

YES	NO		YES	NO	
_____	_____	Anemia	_____	_____	Head Aches
_____	_____	Allergy	_____	_____	Heart Disease
_____	_____	Arthritis	_____	_____	Hemophilia
_____	_____	Asthma/Breathing Problems	_____	_____	Hepatitis – Type _____
_____	_____	Autism	_____	_____	Immune Deficiency/Infections
_____	_____	Birth Defects	_____	_____	Injury/Trauma
_____	_____	Brain Injury	_____	_____	Jaundice
_____	_____	Cancer/Tumors	_____	_____	Learning Disabilities/Developmental Delay
_____	_____	Cerebral Palsy	_____	_____	Leukemia
_____	_____	Chicken Pox or Vaccine	_____	_____	Mental Retardation
_____	_____	Cleft Lip/Palate	_____	_____	Nutritional Deficiency
_____	_____	Convulsions/Seizures	_____	_____	Orthopedic Problems
_____	_____	Diabetes	_____	_____	Rheumatic Fever
_____	_____	Emotional Disturbance/Social Issues	_____	_____	Scoliosis
_____	_____	Epilepsy	_____	_____	Sickle Cell Anemia
_____	_____	Eye Problems	_____	_____	Spina Bifida
_____	_____	Excessive Bleeding Problem	_____	_____	Tetanus
_____	_____	Fainting	_____	_____	Whooping Cough
_____	_____	Hearing Loss	_____	_____	Other

DENTAL HISTORY

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

Reason for bringing child for this visit? _____

Name of child's previous dentist: _____ Date of last visit _____

Has your child had dental radiographs (x-rays)? YES NO

If yes, where were they last taken? _____

Has your child ever had local anesthesia (Novocaine)? YES NO

If yes, were there any complications? _____

Does your child respond well to his/her pediatrician? YES NO

Describe your child's temperament _____

Please indicate if your child has or has had any of the following oral habits:

Breathes through mouthYES NO

Sucks thumb or fingerYES NO If yes, until what age? _____

Uses a pacifierYES NO If yes, until what age? _____

Bites or sucks lipsYES NO

Tongue habitYES NO

Bottle to bedYES NO If yes, until what age? _____

Other _____

Any previous history of traumatic injury to teeth or mouth area? YES NO

If yes, please explain _____

Do you live in a community with fluoridated water? YES NO

Does your child drink tap water? YES NO

Does your child use any fluoride supplements (rinses, vitamins)? YES NO

If yes, name of product _____

How often and when does your child brush his/her teeth? _____

Brand of toothpaste? _____

Type of toothbrush? Hard _____ Soft _____

Does your child floss his/her teeth? YES NO

When _____

Is there parental assistance or supervision when:

Brushing? YES NO

Flossing? YES NO

Any history of jaw pain (tempromandibular joint pain)? YES NO

If yes, please explain _____

Additional Remarks: _____

THE SIGNATURE OF A PARENT OR GUARDIAN BELOW AUTHORIZES THE COMPLETION OF ALL AGREED-UPON NECESSARY DENTAL SERVICES.

SIGNATURE _____

DATE _____

RELATIONSHIP _____

PLEASE BRING THIS COMPLETED FORM TO YOUR CHILD'S INITIAL APPOINTMENT.

TO BE COMPLETED BY REVIEWER:

MEDICAL HISTORY SUMMARY:
(Precautions, medical entities, SBE)

DENTAL HISTORY SUMMARY:
(Previous experience, OHI, F1 Hx)

Reviewer _____ Date _____

MEDICAL HISTORY UPDATES (to be completed at subsequent visits by parent or guardian)

DATE _____

Please review the original patient information. If there are any changes in the history, please comment below. If there are no changes, please so state.

Parent's Signature _____ Reviewer _____

DATE _____

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