everyone by one

pediatric dentistry

CHILD'S FULL NAME: _____

BIRTHDAY: _____ AGE _____ MALE / FEMALE

MEDICAL HISTORY

Who is your child's current pediatrician? Name/Clinic _____

1. Is your child taking any medication (prescription or over the counter), vitamins or supplements? **YES NO**
   - List name, dose and frequency: _____
2. Is your child under the care of a physician for any medical condition at this time? **YES NO**
   - If yes, please explain: _____
3. Has your child ever been hospitalized, had surgery or been treated in an emergency room? **YES NO**
   - If yes, date and please explain: _____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS?

Anemia / Blood Disorder	**Y**	**N**	Bladder / Kidney Problems	**Y**	**N**
Asthma / Difficulty Breathing	**Y**	**N**	Liver Disorder	**Y**	**N**
Allergies to Food / Latex / Seasonal / Other	**Y**	**N**	Allergic Reaction to Anesthetic / Antibiotics / Other	**Y**	**N**
Cancer / Tumors / Chemo or Radiation Therapy	**Y**	**N**	Thyroid Disorder	**Y**	**N**
Diabetes / Hyperglycemia / Hypoglycemia	**Y**	**N**	Birth Defects / Syndromes	**Y**	**N**
Cerebral Palsy / Epilepsy / Seizures	**Y**	**N**	Vision / Hearing / Speech Problems	**Y**	**N**
Heart Defects / Heart Disease / Murmur	**Y**	**N**	Behavioral / Emotional Issues / ADD / ADHD	**Y**	**N**
HIV / AIDS	**Y**	**N**	Developmental Disorders / Learning Problems / Delays	**Y**	**N**
Hepatitis	**Y**	**N**	Autism / Autism Spectrum Disorder	**Y**	**N**

For each **YES** provide details here: _____

_____

DENTAL HISTORY

Has your child ever been treated by a general or pediatric dentist? **YES NO**

- If so, who? _____ Date of last visit: _____

1. How do you expect your child to respond to dental treatment? **WELL FAIR POOR**
2. Is there a family history of cavities? **YES NO** If yes, who? **FATHER MOTHER SIBLING(S)**

DO ANY OF THESE **CURRENTLY** APPLY TO YOUR CHILD?

Cavities / Pain from Teeth	**Y**	**N**	Sucking Habits (finger, thumb, pacifier, other)	**Y**	**N**
Injury to Teeth / Mouth / Head / Lips	**Y**	**N**	Non-Spill Training Cup (sippy cup)	**Y**	**N**
Breast or Bottle Feeding	**Y**	**N**	Stained or Discolored Teeth	**Y**	**N**

I am the parent or legal guardian for the above referenced child and am authorized to consent to dental treatment for such child. I have complete knowledge of this child's medical/dental history to accurately and fully complete this form for the child.

_____

Parent / Legal Guardian Signature Date

Please email form to business@everyonebyone.com or fax to 425-451-4029