NORMAN D. JACOBSKIND, DDS PC

PROFESSIONAL DENTAL SOLUTIONS

Child Medical / Dental History

Medical History

Physician's name _____ Town _____ Last visit *(approximately)* _____

Please list any past serious illnesses or operations _____ Date *(approximately)* _____

_____ _____

_____ _____

Please indicate if your child has/had:

	Y	N		Y	N		Y	N		Y	N
Anemia	☐	☐	Cancer	☐	☐	Immune disorders	☐	☐	Rheumatic fever	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Kidney disease	☐	☐	Seasonal allergies	☐	☐
Use an inhaler?	☐	☐	Fainting	☐	☐	Liver disease	☐	☐	Seizures/convulsions	☐	☐
Blood/bleeding disorders	☐	☐	Heart disease	☐	☐	Low blood pressure	☐	☐	Thyroid disease	☐	☐
Bruising (frequently)	☐	☐	Heart murmur	☐	☐	Pneumonia	☐	☐	Tuberculosis	☐	☐
Bladder problems	☐	☐	High blood pressure	☐	☐						

Please list any medications your child is taking:

_____ _____ _____

_____ _____ _____

Please list medication allergies (i.e. penicillin):

_____ _____

_____ _____

Speech/hearing problems Y N If yes, explain _____

Learning/developmental delays Y N If yes, explain _____

Are your child's immunizations up to date? Y N

Please describe any current or upcoming medical treatment (i.e. drugs, surgeries) not yet covered on this form:

_____

Dental History

Reason for today's visit _____

Is this your child's first dental visit? Y N If no, former dentist _____ If no, last dental visit _____

Please indicate if your child has/had:

	Y	N		Y	N		Y	N
Bad breath	☐	☐	Nail biting	☐	☐	**If under 5 years old:**		
Blisters/sores on lips or mouth	☐	☐	Tongue/cheek biting (often)	☐	☐	Breast fed	☐	☐
Clenching/grinding teeth	☐	☐	Tongue thrust	☐	☐	Frequent bottle use	☐	☐
						Thumb/finger sucking	☐	☐
						Use of a pacifier	☐	☐

How often does your child brush? _____ How often does your child floss? _____ Do you assist him/her? Y N

Has your child ever had local anesthesia (i.e. Novocaine)? Y N

Is your child currently experiencing any oral pain? Y N If yes, explain _____

Has your child ever had trouble with previous dental care? Y N If yes, explain _____

Is there anything else in your child's medical/dental history not indicated on this form? _____

The information I have provided on this page is accurate, to the best of my knowledge. I further understand that by signing this form, I grant permission for any necessary dental work to be performed on the minor whose name appears at the top of these intake forms. I also acknowledge my responsibility for any professional fees incurred for dental services provided to my child.

_____ _____ _____

Patient name (printed) | Signature (of parent/guardian, if under 18) | Date

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