LAURA B. GLICKSMAN, MS, DMD

Medical Dental History Form for Patients under 18 years of age

CONFIDENTIAL DATE_____

Patient's Name_____Phone No._____

Birthdate_____ Age_____ Nickname/ Prefers to be called_____

Gender Assigned at Birth M_____ F_____ Preferred pronouns: He/Him She/Her They/Them

Patient's Address_____City_____State____Zip Code_____

School_____ Grade_____ Musical Instruments Played_____

Sports And/Or Hobbies_____

Siblings/ Date of Birth_____

Parent 1 Name_____Occupation_____Employed by_____

Parent 2 Name_____Occupation_____Employed by_____

Marital Status S__M__D__W__ Parent 1 cell # _____ Parent 2 cell #_____

Person Financially Responsible _____Relationship to Patient _____

Addresss (if different than patient's) _____

Phone No. (if Different)_____E-Mail_____ Cell_____

Patient's Dentist:_____Address:_____

Date Last Seen: _____Reason_____

Patient's Physician:_____Address:_____

Date Last Seen: _____Reason_____

Patient referred by_____

Dental Ins____ Dental Insurance Co._____ Subscriber #_____

Subscriber Name_____DOB_____Group #_____

PATIENT'S PROFILE

Does patient follow directions well? _____

Does patient brush his/her teeth conscientiously?_____

Is patient sensitive or self-conscious about teeth?_____

Does patient have any problems with dexterity or fine motor skills?_____

Does patient have anxiety? _____

PLEASE TURN OVER TO COMPLETE FORM

Medical History

Now or in the past, has the patient had:

ADD/ADHD ____Y____N

Herpes _____ Y____N

Rheumatoid or arthritic conditions ___Y__N

Endocrine or thyroid problem __Y__N

Diabetes __Y__N

Cancer, tumor, radiation or chemotherapy __Y__N

Mononucleosis, tuberculosis or pneumonia __Y__N

Asthma __ Y ___N

Fainting spells, seizures, epilepsy or neurological problem _Y_N

AIDS/HIV __Y__N

History of eating disorder (anorexia, bulimia) ___Y__N

High or low blood pressure __Y__N

Heart problem ___Y__N

Frequent headaches, colds or sore throats __Y__N

Tonsil or adenoid conditions __Y__N

Injury to face or teeth __Y __N

Allergies or reactions to any of the following:

Aspirin _____

Ibuprofen (Motrin, Advil) _____

Penicillin or other antibiotics _____

Sulfa drugs _____

Metals (jewelry, clothing snaps) _____

Vinyl ____

Acrylic _____

Animals _____

Foods(specify) _____

Latex _____

Environmental/pollen___

Is the patient taking any medications (please name them)_____

Hospitalized _____ For_____

Under the care of a doctor now _____ For _____

Has patient reached puberty _____

DENTAL HISTORY

Now or in the past, has the patient had:

Snoring _____
Thumb, finger, or sucking habit _____
Abnormal swallowing habit (tongue thrusting) _____
History of speech problems _____
Mouth breathing or difficulty breathing _____
Tooth grinding, jaw clenching clicking or locking _____
Any pain in the jaw or ringing in the ears _____
Any pain or soreness in the muscles around the face or ears _____
Difficulty in chewing or jaw opening _____

Concerned about under or over developed jaw _____
Frequent cankers or cold sores _____
Taking any forms of fluoride _____
Any relatives with similar tooth or jaw relationships__
Any serious problems with dental procedures _____
Ever had prior orthodontic exam or treatment _____
Nail Biting _____
Patient's feeling towards braces
Unhappy------1------2------3------4-------Eager

How often does your child brush _____ Floss _____

What is your primary concern _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical/dental status. I authorize the dental staff to \perform the necessary dental services my child may need.

Signature of Parent or Guardian_____ Date _____

The parent or guardian that accompanies the child is responsible for payment.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, CDC and ADA