PEDIATRIC DENTISTRY OF NORTHBROOK & HIGHLAND PARK

HEALTH HISTORY

Patient's Name M / F Birthdate

Patient's Address City, State & Zip

Email

Referred by

Mother/Guardian Birthdate SSN

Home # Cell # Text message reminders? Y / N

Employer Work #

Father/Guardian Birthdate SSN

Home # Cell # Text message reminders? Y / N

Employer Work #

Billing Information (if different from above)

Name Address

PATIENT'S MEDICAL HISTORY (please circle Yes or No)

Is the patient under any medical treatment now? **Yes** **No** If yes, why? _____

Has the patient ever been hospitalized? **Yes** **No** If yes, why? _____

Does the patient have any allergies? (please circle) **Penicillin** **Sulfa** **Red Dye** **Latex** **Local Anesthetic** **Aspirin** **Pain Medications** **Other** _____

Does the patient have a speech, cognitive, or emotional difference that may impact treatment? **Yes** **No**

Does the patient have or has the patient had any of the conditions listed? (please circle)

Asthma	**Seizure Disorders**	**Down Syndrome**	**ADHD**
Diabetes	**Kidney/Liver Disease**	**HIV Positive/AIDS**	**Learning Disabilities**
Celiac Disease	**Blood Disease**	**Prolonged Bleeding**	**Autistic Spectrum**
Ear Infections	**Respiratory Disease**	**Vision/Hearing Impaired**	**Depression/Anxiety**
Strep Throat	**Tumors/Growths**	**Hepatitis**	**Other** _____

Does the patient have any heart problems, defects, or murmurs? **Yes** **No**

Does the patient require antibiotics for dental work? **Yes** **No**

Is the patient currently taking any drugs or medications? **Yes** **No**

If yes, what/purpose? _____

Any other information to be known about the patient's health? **Yes** **No**

If yes, what? _____

I, the undersigned (patient or legally responsible party), will keep you informed if changes occur in the patient's health.

Signature Date