Aimee Snell-Killam DDS MS
Pediatric Dentist
Bigbluedental.com

Medical/Health History

Patients Name_____ Birthdate_____ Today's Date_____

Dental History

Is this your child's first visit to the dentist? ☐Yes ☐No
If No, when was their last visit_____
Previous Dentist Name _____
Were any x-rays taken at the previous visit? ☐Yes ☐No
Have any cavities been noted in the past? ☐Yes ☐No
Has your child had any problem with dental treatment?
If so please explain _____
_____
Have they ever received local anesthetic? ☐Yes ☐No
Has your child ever had sealants placed? ☐Yes ☐No
Have there been any injuries to your child's teeth or face (falls, blows, chips etc.)? Please explain_____
_____
Does your child receive fluoride by any of the following?
☐Water ☐Toothpaste ☐Drops ☐Tablets ☐Rinse or Gel

How often does your child brush_____
How often does your child floss_____
Does your child have any of the following habits?
☐Nursing/Bottle at night ☐Lip Sucking/Biting
☐Pacifier ☐Grinding
☐Thumb/Finger sucking ☐Snoring
☐Nail Biting ☐Mouth Breathing

Are there any other considerations we should know about when treating your child? (anti-fluoride, non-vacc, x-ray concerns etc.)_____
_____
Why did you bring your child to the dentist? _____
_____

Medical History

Child's Pediatrician_____
Pediatrician's Phone_____
Is your child seeing any medical specialist? ☐Yes ☐No
If so, Name_____
Phone Number_____
Drugs/Medications your child is taking_____
_____
Please list any allergies (drugs, latex, food etc.)_____
_____
Has your child ever had surgery_____
_____
Please discuss any serious medical conditions_____
_____
_____

Has your child had any of the following conditions?

- ☐ ADD/ADHD
- ☐ AIDS/HIV+
- ☐ Allergies
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disorders
- ☐ Bone/Muscle Disorder
- ☐ Cancer
- ☐ Congenital Birth Defect
- ☐ Convulsions/Epilepsy
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Disabilities/Special Needs
- ☐ Eating Disorder
- ☐ Hearing/Visual Impairment
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ Hospital Stays
- ☐ Immune Disorder
- ☐ Kidney/Liver Conditions
- ☐ Rheumatic/Scarlet Fever
- ☐ Tuberculosis

Please Describe any conditions checked _____
_____

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

Signature of parent _____ Date_____
Doctor Signature _____ Date_____