DR. BETH COOK
Pediatric Dentistry of South Charlotte
Specializing in dental care for infants, children and adolescents

New Patient Medical and Dental History
Welcome to our office! Careful completion of this form will assist us in providing your child with the best possible dental care.

Child's Name _____ Today's Date ___/___/_____

Name and phone number of child's primary care physician _____

Is your child under the care of any specialist physician? [ ] Yes [ ] No

If so, please state name and specialty_____

When was your child's last medical check-up? _____

Are all immunizations current? [ ] Yes [ ] No

Is your child allergic to anything? (e.g. Medications, Latex, Foods) [ ] Yes [ ] No

If so, what? _____

Is your child taking any medications at this time? [ ] Yes [ ] No

If so, what? _____

Has your child ever been hospitalized? [ ] Yes [ ] No

If so, what for? _____

Has your child ever had surgery or general anesthesia? [ ] Yes [ ] No

If so, what for and were there any complications? _____

Has your child ever been diagnosed as having any of the following conditions?

[ ] ADD/ADHD	[ ] Congenital Birth Defects	[ ] Nutritional Deficiency
[ ] Anemia	[ ] Diabetes	[ ] Orthopedic Problems
[ ] Arthritis	[ ] Emotional Disturbance	[ ] Premature Birth
[ ] Asthma	[ ] Eye Problems	[ ] Pregnancy
[ ] Autism	[ ] Fainting	[ ] Respiratory Syncytial Virus
[ ] Brain Injury	[ ] Handicaps/Disabilities	[ ] Seizure Disorder
[ ] Behavioral Problems	[ ] Hearing Impairment	[ ] Sickle Cell Anemia/Trait
[ ] Bleeding Problems	[ ] Heart condition/Heart murmur	[ ] Speech Problems
[ ] Breathing problems	[ ] Hemophilia	[ ] Spina Bifida
[ ] Cancer/Leukemia	[ ] Hepatitis	[ ] Syndrome _____
[ ] Cerebral Palsy	[ ] Kidney/Liver Problems	[ ] Tetanus
[ ] Cleft Lip/Palate	[ ] Learning Disability	[ ] Other _____

Is this your child's first visit to the dentist? [ ] Yes [ ] No

If not, how long since the last visit to the dentist? _____ Were x-rays taken? [ ] Yes [ ] No

Previous dentist's name? _____

Has your child ever had any injuries to the teeth, face or mouth? [ ] Yes [ ] No

If yes, please explain _____

Does your child have any of the following habits?

Thumb/finger sucking [ ] Yes [ ] No Lip Sucking/Biting [ ] Yes [ ] No Nail Biting [ ] Yes [ ] No

Does your child nurse or take a bottle? [ ] Yes [ ] No

How often are child's teeth brushed? _____ How often are they flossed? _____

Is your child's water fluoridated? [ ] Yes [[No Is the child receiving fluoride supplements? [ ] Yes [ ] No

Has your child ever had a serious or difficult problem associated with previous dental work? [ ] Yes [ ] No

If yes, please explain _____

What is your reason for bringing your child to the dentist today? _____

How do you think your child will react today? (e.g. Shy, anxious, cooperative, defiant)_____

Is there anything else you think we should know about your child? _____

Name _____ **Signature**_____