866 Seven Hills Drive #102
Henderson, NV 89052
P: 702 805 8185
F: 702 805 8189
Info@firstbitedental.com

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone_____
Please circle Yes or No (If Yes, please fill in details)
Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any surgeries? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that the patient has had or currently has.

ADHD
AIDS/HIV+
Allergies
Asthma
Autism
Blood/Bleeding Disorders
Bone/Muscle Disorder
Cancer
Congenital Birth Defect
Epilepsy/Seizures
Depression/Anxiety
Diabetes
Developmental Delay
Eating Disorder
Hearing/Visual Impairment
Heart Disease/Murmur
Hepatitis
Hospitalizations
Immune Disorder
Kidney/Liver Conditions
Rheumatic/Scarlet Fever
Tuberculosis

Please describe any conditions circled
_____
_____

Are there any medical conditions we have not discussed that you feel we should be aware of?
_____
_____

DENTAL HISTORY

Is this your child's first visit to the dentist? ___ If no, date of last visit _____
Previous Dentist/Dental Office name_____
How often does your child brush and floss _____

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Does your child have any of the following habits? Circle any that apply

Nursing/bottle at night	Lip sucking/biting
Pacifier	Grinding
Thumb/finger sucking	Snoring/sleep apnea
Nail biting	Mouth breathing

Yes No Is the patient presently in any dental pain?
Yes No Have there been any injuries to face, mouth, or teeth?
Yes No Has the patient ever lost or chipped any teeth?
Yes No Have there been any cavities noted in the past?
Yes No Have your child ever received local anesthetic/numbing?
Yes No Has your child had any problems with dental treatment?
If so, please explain:

_____
_____

Yes No Has your child ever had sealants placed?
Yes No Does your child receive fluoride (water, toothpaste, rinse, etc)?
Yes No Has the patient ever seen an orthodontist? If yes, who and when?
Yes No Is the patient sensitive or self-conscious about his/her teeth?
Yes No Are you aware that appointments will be during school hours?

Are there any other considerations we should know about when treating your child? (no fluoride, non-vaccinated, x-ray concerns, etc)?

_____
_____

What is your main concern for today's visit?

_____
_____

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 to my child's medical status. **I authorize the dental staff to perform the necessary dental services my child may need such as xrays and fluoride for today's visit, unless otherwise stated**.

Parent/Guardian Signature: _____ Date:
Doctor Signature: _____ Date: