Wilson Dental, PC (Syracuse)
224 S. Geddes Street
Syracuse, NY 13204
Ph. #: 315.423.9900
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CHILD'S INFORMATION AND HEALTH HISTORY

Child's Name __________________________________ Nickname:______________ Age:__________

Date Of Birth: ______________

Childs Address ______________________________________ Phone Number: ___________________

Pharmacy Name and Address:____

Referred by: ____

MEDICAL HISTORY

Child's Physician or Pediatrician ___________________ Address_______________________________
Phone # __________________

Has your child had a physical exam within the last year? ___________________Date______________

Has your child received emergency medical treatment within the last six months? Y/N
Reason ____

Does your child have a heart condition or heart murmur? Y/N
Explain: ____

Have you ever been told that your Child should have antibiotics before all dental appointments? Y/N

Has your child ever been hospitalized? Y/N
Reason____

Has your child ever had a serious illness or operation? Y/N
Explain:____

Has your child had a blood transfusion or received any clotting agents? Y/N
Date ?_______________

Does your family or your child have a history of complication from general anesthesia? Y/N
If so, what type?
____

Has your child received injuries to the head, jaw, mouth or teeth? Y/N
Explain: ____

Is your child now taking any medications? Y/N
List/dosage____
____
____
____

List all of your child's allergies, include adverse reactions to any drugs or medications. (If none, write "none")

____

If your child has or has had any of the following, please circle yes or no on the lines below:

Condition		Condition		Condition	
Loss of Consciousness	Y/N	Muscle Disorders	Y/N	Skin Diseases	Y/N
Glandular Problems	Y/N	Blood Disease	Y/N	Bacterial Infections	Y/N
Autism Spectrum	Y/N	Hemophilia	Y/N	Viral Infections	Y/N
Diabetes	Y/N	Congenital Birth Defects	Y/N	Asthma	Y/N
Convulsions	Y/N	Bleeding Tendency	Y/N	Breathing Difficulties	Y/N
Thyroid Disease	Y/N	Endocrine Disorder	Y/N	Lung Disease	Y/N
Psychiatric Treatment	Y/N	High Blood Pressure	Y/N	Pneumonia	Y/N
Heart Murmur	Y/N	Kidney Disease	Y/N	Nose/Throat Disorder	Y/N
Seizures	Y/N	Bladder Disease	Y/N	Cleft Lip/Palate	Y/N
Mitral Valve Prolapse	Y/N	Liver Disease (Jaundice)	Y/N	Recurrent Headaches	Y/N
Epilepsy	Y/N	Stomach Problems (Ulcers)	Y/N	Immunosuppression Deficiency	Y/N
Heart Conditions	Y/N	Gastrointestinal Disorders	Y/N	Hyperactivity	Y/N
Emotional Problems	Y/N	Cancer or Tumors	Y/N	Arthritis	Y/N
Rheumatic Fever	Y/N	Anemia	Y/N	Bone Disorders	Y/N
Eye Disorders	Y/N	Sickle Cell Anemia	Y/N		
Ear Disorders	Y/N	Attention Deficit Syndrome	Y/N		

Does your child have any other medical condition not mentioned above? Explain?

____

____

____

Is there a chance your child is pregnant? Y/N

Dentistry for the Disabled and Medically Compromised

Does your child have any physical or mental special needs
(Autism, Down Syndrome, Cerebral Palsy, ETC) ? Y/N
Explain:____

Has your child ever had hearing, sight or speech problems? Y/N
Explain ____

Is your child currently receiving speech therapy? Y/N
If Yes by Whom ? ____

Has your child ever had learning or behavioral problems (ADD, ADHD, OCD) ? Y/N
Explain:____

How would you describe your child's personality/temperament? ____________________________

DENTAL HISTORY

Is this your child's first visit to the dentist? Y/N

Date of last dental exam__________ Any previous unfavorable dental experience Yes/ No
Explain:____

Were X-rays taken? Y/N   Date of last X-rays? _____________

Has your child had a toothache recently? Y/N

Is there a history of oral habits? Please circle: Mouth breathing / Thumb sucking / Finger sucking / Pacifier sucking / Lip biting or sucking / Nail biting

Is your child currently nursing or taking a bottle? _______________
How many bottles per day? _______________

Does he/she take the bottle before or to bed? Y/N Contents of bottle? _______________________

At what age did your child stop nursing or taking a bottle? ______________

Is your child taking any vitamins with fluoride supplements? Y/N

Does your child use a fluoride rinse? Y/N

Has your child ever had a dentist applied fluoride treatment? Y/N

Do you have fluoride in your water system? Y/N

How often are your child's teeth brushed per day? _____________ By whom? __________________

Does he/she snore when sleeping? Y/N Is there a history of "night grinding" while sleeping? Y/N

Chief Complaint/Reason for visit
____

Is there anything else about your child that you think we should know in order to better treat his/her dental needs? ____

CONSENT

Your child is a minor. Therefore, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin: I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical / surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. If my child ever has a change in his / her health or his / her medications change, I will inform the doctor at the next appointment without fail.

Legal Parent Name: _______________________________

Legal Parent Signature: _____________________________ **Date:** _________________