Acorn Pediatric Dental
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(732) 852-9200

Please fill out one per child being treated

Medical & Dental History

Patient's Name ____ Birthdate ________ / ________ / _________

Has your child ever had a serious/difficult problem associated with previous dental work? Yes No
If Yes, please explain: ____
What is the reason for today's dental visit?: ____
Does the child brush his/her teeth daily? Yes No
Has your child ever injured their mouth, teeth, or head? If yes, please explain: Yes No
Child's Physician: _____________________________________ Phone Number: _____________________________
Date of last visit: _____________________________________
Please describe the child's current physical health: Good Fair Poor
Is the child up to date on all immunizations? If not, please explain. Yes No ____________________
Please list all medications the child is currently taking: ____
Aside from the items listed below, please list anything the child is allergic to, including medication: _____________
Latex: Yes No Metals/Silver: Yes No Plastic: Yes No

Has the child ever had any of the following medical issues?

Abnormal Bleeding	Yes	No	Heart Defects	Yes	No	Liver Problems	Yes	No
ADD/ADHD	Yes	No	Cancer	Yes	No	Measles	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	Mononucleosis	Yes	No
Any Hospital Stays	Yes	No	Epilepsy	Yes	No	Sensory Issues	Yes	No
Any Operations	Yes	No	Headaches	Yes	No	Skin Rash	Yes	No
Asthma	Yes	No	Hemophilia	Yes	No	Snoring	Yes	No
Autism/Asperger's	Yes	No	HIV/AIDS	Yes	No	Speech Delay	Yes	No
Convulsions	Yes	No	Kidney Problems	Yes	No	Tuberculosis (TB)	Yes	No

Other: ________________________

If **yes** to any of the above, please describe: ____

Has a physician ever advised your child to take antibiotics prior to dental treatment? If yes, explain: Yes No

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

Parent/Guardian Signature ____ Date _____________________________