Sprout
PEDIATRIC DENTISTRY

health history

Physician/Pediatrician: _____
Medications (including OTC): _____
Allergies to medications: ❑ No ❑ Yes, what? _____ Reaction: _____
Allergies to food/materials/dyes/etc: ❑ No ❑ Yes, what? Reaction: _____
History of surgery or general anesthesia: ❑ No ❑ Yes, When? Why? _____
History of sedation: ❑ No ❑ Yes, When? Why? _____
Pre-medication needed before dental treatment? ❑ No ❑ Yes, why? _____

has your child ever had any of the following medical conditions?

❑ ADD/ADHD	❑ Cancer	❑ Fainting	❑ Nutritional Disturbances
❑ Allergy/hay fever	❑ Congenital heart disease	❑ Hearing problem	❑ Organ Transplant
❑ Anemia/sickle cell	❑ Cerebral palsy	❑ Heart murmur	❑ Pneumonia
❑ Arthritis	❑ Chemo/radiation	❑ Heart problem/surgery	❑ Pregnancy
❑ Artificial joint or limb	❑ Cleft lip/palate	❑ Hemophilia	❑ Reactive Airway Disease
❑ Asthma	❑ Convulsions/seizures	❑ Hepatitis A, B, or C	❑ Respiratory Problem
❑ Autism/aspergers	❑ Diabetes	❑ High/low blood pressure	❑ Sensory Issues
❑ Behavior/learning disability	❑ Digestive problem	❑ HIV/AIDS	❑ Shunts (VS, VV, VP)
❑ Birth defect	❑ Down syndrome	❑ Intellectual Disability	❑ Surgeries
❑ Bleeding disorder	❑ Ear tubes	❑ Kidney/Liver Problem	❑ Tuberculosis
❑ Bone/joint Problem	❑ Emotional disturbances	❑ Malignant Hyperthermia	❑ Venereal Disease
❑ Brain surgery	❑ Eye problems	❑ MTHFR mutation	❑ Other:

further explanation of checked condition: _____

dental history

Is this your child's first dental visit? ❑ No ❑ Yes If **no**, when was the last visit? _____
Is your child in pain? ❑ No ❑ Yes
Is there a dental condition that you are concerned about? _____
Any past trauma to the teeth? ❑ No ❑ Yes If **yes**, explain
_____
Problems with previous dental treatment? ❑ No ❑ Yes If **yes**, explain: _____
Other information that may help us make this appointment great for your child: _____

dental habits

Brushing frequency: _____ Flossing frequency: _____
Type of toothbrush: ❑ Regular ❑ Electric ❑ Other
Who is responsible for brushing: ❑ Parent ❑ Child ❑ Both
Type of toothpaste: _____ Is it fluoridated? ❑ Yes ❑ No Does it have hydroxyapatite? ❑ Yes ❑ No
Non-nutritive habits: ❑Pacifier ❑ Thumb sucking ❑ Grinding ❑ Mouth breathing ❑ Other

I understand that the information I have given is correct to the best of my knowledge. The information will be held in the strictest confidence. I understand that it is my responsibility to inform Sprout Pediatric Dentistry of any changes to my child's medical status. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents, including any unpaid insurance claims as we do not guarantee insurance payment or benefits.

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Parent/Legal Guardian Signature Date