KIDSHINE PEDIATRIC DENTAL GROUP
DAVID CHING, D.M.D.
LAUREN YOUNG, D.D.S.
TIAN HE, D.M.D.

CONFIDENTIAL

MEDICAL & DENTAL HISTORY

Name_____ **Birth Date** _____ **Today's Date** _____

Reason for today's visit: _____

Date of your child's last dental visit: _____ What was done: _____

How many times a day does your child brush? _____ Floss? _____

Does or has your child:	**YES**	**NO**		**YES**	**NO**
Suck Thumb/Finger	☐	☐	Take Fluoride Supplements	☐	☐
Clench or Grind Their Teeth	☐	☐	Chew Hard Objects (pencils, etc.)	☐	☐
Play any Contact Sports	☐	☐	Had any Head/Neck/Jaw Injuries	☐	☐

Although we primarily treat the area in and around your mouth, any health problems and medications that you may be taking can have an effect on the dental care we provide for you. Thank you for answering the following medical health questions.

	YES	**NO**		**YES**	**NO**
Is your child in good health?	☐	☐	Is your child under the care of a physician now?	☐	☐

Has your child ever been hospitalized since birth?_____ If so, why? _____

_____

Please list any medications, including non-prescription:_____

_____

Has your child ever had any of the following:

YES	**NO**		**YES**	**NO**	
☐	☐	Tonsil/Adenoid problems	☐	☐	Cleft Lip and Palate
☐	☐	Heart Disease	☐	☐	Diabetes Type _____
☐	☐	Congenital Heart Defect / What Type _____	☐	☐	Epilepsy/Seizures/Fainting Spells. How Often_____
☐	☐	History of Heart Problems	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Allergies to Antibiotics. List Type _____
☐	☐	Asthma/Hay Fever	☐	☐	Allergies to Anesthetic
☐	☐	Cancer Type _____	☐	☐	Allergies to Latex
☐	☐	Kidney Disease	☐	☐	Other Allergies _____
☐	☐	Hepatitis/Jaundice/Liver Disease	☐	☐	Special Needs Type _____
☐	☐	Aids or HIV Infection	☐	☐	Attention Deficit Disorder/Behavior Problems
☐	☐	Hemophilia Type _____	☐	☐	Eating Disorder/Problems Feeding
☐	☐	Abnormal Bleeding	☐	☐	Psychological/Emotional Problems
☐	☐	History of Infective Endocarditic	☐	☐	Learning Disability
☐	☐	Any Organ Transplant	☐	☐	Any Type of Abuse
☐	☐	Any Surgeries	☐	☐	Pregnant

Does your child have any disease, condition, or problem not listed above that you think we should be aware of? _____

_____

Physician's Name:_____ Physician's Phone #: _____

PLEASE READ CAREFULLY BEFORE SIGNING. IF YOU HAVE QUESTIONS OR DO NOT UNDERSTAND, PLEASE DISCUSS THIS STATEMENT WITH OUR STAFF BEFORE SIGNING.

I certify that I have read, understand and provided the above information to the best of my knowledge. I have answered the questions above as accurately as possible. I understand that providing incorrect information can be dangerous to my child's health. I understand it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Dr. David Ching, Dr. Lauren Young, Dr. Tuan He and staff to gather clinical information, diagnose and perform treatment necessary for my child's dental health care needs.

_____ _____

Signature of Parent/Guardian Date