



Mary George, D.M.D.
Diplomate, American Board
of Pediatric Dentistry

Gina Sajnani, D.M.D.
Diplomate, American Board
of Pediatric Dentistry

173 East Shore Road, Suite 201, Great Neck, NY 11023 (516) 487-8110

CHILD'S INFORMATION AND HEALTH HISTORY

Child's name: _____ Nickname _____ Age _____ Birthdate _____
 Child's Address: _____ Child's Phone: _____
 Hobbies, Sports, Interests: _____
 Referred by: _____

I. MEDICAL HISTORY

Child's Physican or Pediatrician _____ Address _____ Phone No. _____
 Has your child had a physical exam within the last year? _____ Date _____
 Has your child received emergency medical treatment within the last six months? _____
 Reason _____
 Does your child have a heart condition or heart murmur? _____ Explain _____
 Have you ever been told that your Child should have antibiotics before all dental appointments? _____
 Has your child ever been hospitalized? _____ Date _____ Reason _____

 Has your child ever had a serious illness or operation? _____ Please list _____
 Has your child had a blood transfusion or received any clotting agents? _____
 Date _____ Reason _____
 Does your family or your child have a history of complication from general anesthesia? _____
 If so, what type? _____
 Has your child received injuries to the head, jaw, mouth or teeth? _____ Describe _____
 Has your child experienced jaw pain or limitation of jaw movement? _____
 Is your child now taking any medications? _____ 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:

- | | | | |
|--------------------------------|----------------------------------|----------------------------|-------------------------------|
| Y N Loss of consciousness | Y N High blood pressure | Y N Asthma | Y N Glandular problems |
| Y N Autism Spectrum | Y N Kidney disease | Y N Breathing difficulties | Y N Diabetes |
| Y N Convulsions | Y N Bladder disease | Y N Lung disease | Y N Thyroid disease |
| Y N Psychiatric treatment | Y N Liver disease (Jaundice) | Y N Pneumonia | Y N Heart Murmur |
| Y N Seizures | Y N Stomach problems (ulcers) | Y N Nose/Throat disorders | Y N Mitral Valve Prolapse |
| Y N Epilepsy | Y N Gastrointestinal disorders | Y N Cleft Lip/Palate | Y N Heart condition |
| Y N Emotional problems | Y N Cancer or Tumors | Y N Recurrent headaches | Y N Rheumatic fever |
| Y N Alcohol dependency | Y N Chemotherapy/radiotherapy | Y N Eye disorders | Y N Anemia |
| Y N Chemical dependency | Y N Immunosuppression/deficiency | Y N Ear disorders | Y N Sickle Cell Anemia |
| Y N Hyperactivity | Y N HIV Antibody/AIDS | Y N Muscle disorders | Y N Blood disease |
| Y N Attention deficit syndrome | Y N Hepatitis | Y N Arthritis | Y N Hemophilia |
| Y N Congenital Birth Defects | Y N Skin Disease | Y N Bone disorders | Y N Bleeding tendency |
| | | Y N Endocrine disorders | Y N Bacterial/viral infection |

Explain _____

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

Does your child have any physical or mental special needs? _____ Explain _____

Has your child ever had hearing, sight or speech problems? _____ Explain _____

Is your child currently receiving speech therapy? _____ If yes, by whom? _____

Has your child ever had learning or behavioral problems? _____ Explain _____

How would you describe your child's personality/temperment? _____

II. DENTAL HISTORY

Is this your child's first visit to the dentist? _____

Date of last dental exam _____ Any previous unfavorable dental experience Yes No Explain: _____

Were X-rays taken? _____ Date of last X-rays? _____

Has your child had a toothache recently? _____

Is there a history of oral habits? _____ Please circle: Mouthbreathing / 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? _____

Contents of bottle? _____

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

Is your child taking any vitamins with fluoride supplements? _____

Does your child use a fluoride rinse? _____

Has your child ever had a dentist applied fluoride treatment? _____

Do you have fluoride in your water system? _____

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

Does he/she snore when sleeping? _____

Is there a history of "night grinding" while sleeping? _____

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?

III. 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 speciality 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. I will be responsible for the cost of this dental care. At no time will care be rendered to a child without informing parent or guardian of such care along with an estimate of their financial obligation. For specific procedures, further information will always be provided.

Parent's Signature _____ Staff _____ Date _____

Doctor's Signature _____ Date _____