Longmont Pediatric Dentistry
Medical and Dental History

Child's Name ________________________________ Date of Birth __________________

Please complete the following about your child:
What is the main reason you brought your child to our office?

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Who is your child's primary physician? ____

Is your child taking any medications? Yes/No

If yes, what medications? ____

Is your child allergic to anything? Yes/No

If yes, what are they allergic to? ____

Please mark if your child has ever had any of the following:

- o Heart Disease including Murmur
- o Asthma or other Respiratory Disease
- o Jaundice, Hepatitis, Liver Disease
- o Diabetes, Thyroid, Endocrine Disease
- o Kidney Disease
- o Neurologic Disease, Cerebral Palsy
- o Seizures
- o Anemia, Hemophilia, Bleeding Disorders
- o Sickle Cell Disease or Trait
- o Cancer
- o Mental or Developmental Delay
- o Speech, Hearing or Sight Disorder
- o Immune Disorders/HIV/STD
- o Blood Products/Transfusion
- o Hospitalization/Surgery
- o Serious Illness

Please explain any marks or any other medical conditions we should know about:

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Is this your child's first dental visit? Yes/No
Is your child having any dental pain? Yes/No
Has your child had a bad dental experience? Yes/No
Has your child had any dental injuries? Yes/No
Does your water have fluoride? Yes/No
Did your child ever fall asleep with a bottle? Yes/No
Does your child have any habits (pacifier, thumb, etc.)? Yes/No

____________________________________ ____________________________

Parent/Legal Guardian Signature Date

By signing this, you are verifying that all information is correct to the best of your knowledge.

Longmont Pediatric Dentistry
Patient Information Sheet
All information is confidential

PATIENT

Date:	Child's Legal Name:	Nickname:
Address: City: State: Zip:		Place of Birth:
Home Phone Number:	Social Security Number:	
Birthdate:	Age:	Gender:
School:		Grade:
Names and Ages of Siblings:		
Has your child seen the dentist before? If so, was it a good experience?		
Is there anything else we should know about your child to help make their experience better?		

PARENT

Parent(s) or Legal Guardian(s) Name(s):		Relationship to Patient:
Address (if different from patient): City: State: Zip:		
Cell phone number:	Work phone number:	Occupation:
E-mail address:	How did you hear about our office?	

Person Financially Responsible for Account

Name:		Relationship to Patient:
Address (if different from patient and/or other parent): City: State: Zip:		
Phone Number:	Birthdate:	Social Security Number:

Dental Insurance

Primary Dental Insurance		Secondary Dental Insurance	
Insurance Company:		Insurance Company:	
Address:		Address:	
Phone Number:		Phone Number:	
Name of Insured:		Name of Insured:	
Place of Employment:		Place of Employment:	
I.D. Number:	Group Number:	I.D. Number:	Group Number: