Highland Park Family Dentistry, S.C.

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Robin A. Gorman, DDS – Yvonne D. Stubbs, DDS

Child Medical and Dental Form

Patient's Name _____ Birthdate_____
Last First Nickname

Mom's Name _____ Phone # _____ (home, work, cell)
(circle one)

Dad's Name _____ Phone #_____ (home, work, cell)

Dental History

Has your child ever seen a dentist before Y N Last visit to a dentist _____

Has your child had x-rays of their teeth Y N When were they taken _____

Does your child?

* Brush teeth daily Y N * Floss daily Y N * Take fluoride supplements Y N
* Suck thumb/fingers Y N * Use bottle/pacifier Y N * Eat sweets (candy, soda, gum) Y N

Has your child had any injuries to their mouth or teeth Y N

Explain _____

Has your child had any bad experiences with dental visits Y N

Explain _____

Medical History

Physician's Name _____ Phone _____

Is your child?

currently under the care of a physician Y N Explain _____

currently taking any medications Y N Explain _____

allergic to any medications or anesthetic Y N Explain _____

Has your child ever had any of the following:

Heart problems	Y N	Abnormal bleeding	Y N	Respiratory disease	Y N
High blood pressure	Y N	Low blood pressure	Y N	Hepatitis	Y N
Cancer	Y N	Asthma	Y N	Rheumatic Fever	Y N
Epilepsy/convulsions	Y N	AIDS, HIV	Y N	Chemical dependency	Y N

Is there anything else we should know about your child's health? _____

_____

The above information is accurate and complete to the best of my knowledge.

Signature _____ Relationship _____ Date _____

Dentist's signature _____ Date_____