Westdale Dental, PC

Patient: _____ Birth date: ___/___/____ Age: _____ Today's date: ___/___/____

Your current physical health is: Good Fair Poor **Physician's (Medical Doctor) Name: _____**
Please list any prescription, over-the-counter medicines, herbal or diet supplements currently being taken and for what conditions:

_____ to treat _____ _____ to treat _____

_____ to treat _____ _____ to treat _____

Have you ever had or are currently experiencing any of the following diseases or medical conditions? (check all that apply)

- ☐ High Blood Pressure
- ☐ Endocarditis (heart infection)
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Defect (from birth)
- ☐ Anemia/Leukemia
- ☐ Acid Reflux/Heartburn
- ☐ Cancer Type_____ Date _____
- ☐ Radiation/Chemotherapy
- ☐ Sinus Concerns
- ☐ Seasonal allergies/Hay fever
- ☐ Asthma/ needs Inhaler
- ☐ Eating Disorder(s)
- ☐ Fainting/Seizures/Epilepsy
- ☐ Bleeding Disorder
- ☐ Anxiety/Depression
- ☐ Celiac/Auto-immune concerns
- ☐ Diabetes Type_____
- ☐ Insulin Dependent
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV or AIDS
- ☐ Kidney Concerns
- ☐ Tonsils/Adenoids Removed
- ☐ ADHD/ADD

Please list hospitalization (surgeries, emergency room) within the last year: _____

Does your child require any special accommodations? _____

_____

Is your child allergic to any of the following? If so, indicate what kind of reaction:

- ☐ Foods_____
- ☐ Latex _____
- ☐ Metal or Dental Materials _____
- ☐ Local Anesthetics _____
- ☐ Medicines (penicillin, Sulfa, etc)_____
- ☐ Do you have an epi pen _____

Dental Information:

- ☐ Do we have your permission to take the necessary X-rays today?
- ☐ Does your child have a history of sucking his/her thumb, fingers, pacifier?
- ☐ Has your child been raised with fluoride in the drinking water?
- ☐ Does your child clench or grind their teeth?
- ☐ Does your child snore?
- ☐ Does your child have TMJ (jaw joint) pain or trauma?
- ☐ Are your child's teeth brushed twice a day? Do you help? Y or N

Please indicate if you wish to discuss the following regarding your child:

Bad Breath Orthodontics Areas of pain of sensitivity

Is there anything not listed that you think we should know about your child? _____

_____

I acknowledge that I have answered the above questions correctly and to the best of my ability. All my questions regarding this form have been answered to my satisfaction. I will not hold my dentist or many of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____
Parents Signature