# Palouse Pediatric Dentistry

Karen M. Sept, DMD

**Patient's Name: _____** **Date of Birth: ____/____/_____**

## Patient Dental History

Describe your child's brushing habits: _____

_____

| | | |
|---|---|---|
| Do you assist your child while flossing and brushing? | ☐ Yes | ☐ No |
| Do your child's gums bleed while brushing or flossing | ☐ Yes | ☐ No |
| Is your child's water fluoridated? | ☐ Yes | ☐ No |
| Is your child taking fluoride supplements? | ☐ Yes | ☐ No |
| Does your child sleep with a bottle at night? | ☐ Yes | ☐ No |
| Does your child's bottle or sippy cup contain fluid other than milk or water? | ☐ Yes | ☐ No |
| Does your child suck his or her thumb and/or fingers? | ☐ Yes | ☐ No |
| Does your child enjoy chewing gum? | ☐ Yes | ☐ No |
| Has your child had any injuries to his or her mouth, teeth, or head? | ☐ Yes | ☐ No |
| Has your child ever experienced clicking or pain of the jaw? | ☐ Yes | ☐ No |
| Does your child have frequent headaches? | ☐ Yes | ☐ No |
| Does your child clench or grind his or her teeth? | ☐ Yes | ☐ No |
| Is this your child's first dental visit? | ☐ Yes | ☐ No |
| Has your child ever had a negative experience with previous dentists? | ☐ Yes | ☐ No |
| Has your child ever had dental x-rays? | ☐ Yes | ☐ No |
| Has your child ever had general anesthesia? | ☐ Yes | ☐ No |
| Has your child or a family member ever had a problem with general anesthesia? | ☐ Yes | ☐ No |

Other comments or concerns: _____

_____

Parent or Legal Guardian Signature: _____ Date: ____/____/_____

# Palouse Pediatric Dentistry

Karen M. Sept, DMD

**Patient's Name: _____** **Date of Birth: ____/____/_____**

## Patient Medical History

Primary Care Physician: _____ Office Phone Number: _____

Routine Exams? ☐ Yes ☐ No Is your child currently under medical treatment? ☐ Yes ☐ No

Has your child ever been hospitalized? If so, when and why? _____

Does your child currently or have they in the past had any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Fainting | ☐ Yes ☐ No | Heart Trouble | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No |
| Epilepsy/Seizures | ☐ Yes ☐ No | Respiratory Problems | ☐ Yes ☐ No | AIDS or HIV | ☐ Yes ☐ No |
| Bleeding Disorder | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No |
| Anemia/SCA | ☐ Yes ☐ No | Hearing Impairment | ☐ Yes ☐ No | Hay Fever | ☐ Yes ☐ No |
| Premature | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No | Bone/Joint Problems | ☐ Yes ☐ No |
| Blood Transfusions | ☐ Yes ☐ No | Reactive Airway | ☐ Yes ☐ No | Growth Problems | ☐ Yes ☐ No |
| Kidney/Liver Disease | ☐ Yes ☐ No | Tobacco/Drug Use | ☐ Yes ☐ No | Speech Problems | ☐ Yes ☐ No |
| Heart Murmur | ☐ Yes ☐ No | Cancer | ☐ Yes ☐ No | Pregnancy | ☐ Yes ☐ No |
| GERD | ☐ Yes ☐ No | Asthma | ☐ Yes ☐ No | Autism | ☐ Yes ☐ No |
| Sleep Apnea | ☐ Yes ☐ No | ADD/ADHD | ☐ Yes ☐ No | Cerebral Palsy | ☐ Yes ☐ No |

Comments/Other: _____

_____

Is your child taking any medications (including non-prescription medicines and herbal supplements) ☐ Yes ☐ No

If yes, please list medications and dosages: _____

If your child has asthma, when was the last episode? _____

If your child has asthma, when, if ever, did they last have to use albuterol /rescue inhaler?_____

Has your child ever been to the E.R. or been admitted to the hospital for an asthma episode? ☐ Yes ☐ No

Is your child allergic to any of the following (please check all that apply):

☐ Aspirin ☐ Latex ☐ Iodine ☐ Sulfa Drugs ☐ Red Dye ☐ Penicillin ☐ Other Antibiotics ☐ None ☐Other_____

Parent or Legal Guardian Signature: _____ Date: ____/____/_____

Palouse Pediatric Dentistry
Karen M. Sept, DMD

**Authorization, Release, and Agreement to Pay for Services Rendered**

- I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me to third party payers and/or health practitioners.

- I authorize and hereby request my insurance company to pay directly to the dentist (or the dental practice) insurance benefits that otherwise are payable to me.

- I understand that my dental insurance carrier may pay less than the actual bill for services.

- I agree to be responsible for all services rendered on my behalf or on behalf of my dependents.

- I certify that I have read and understand the above information. To the best of my knowledge, the above answers have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

Parent or Legal Guardian Signature: _____ Date: ____/____/_____