CIPES PEDIATRIC DENTISTRY

798 Farmington Avenue, West Hartford, CT 06119

PEDIATRIC MEDICAL HISTORY

Patient Name:____ **D.O.B.:** ____________________

MEDICAL HISTORY UPDATE (ONLINE)

Is your child being treated by a physician at this time? ☐ YES ☐ NO

Reason____

____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐ YES ☐ NO

List name, dose, frequency & date started:_______________________________________

____

Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? ☐ YES ☐ NO

Describe:____

____

Is there any other change in the child's medical, dental, or family history that the dentist should be told? ☐ YES ☐ NO

Describe:____

____

How much does your child weigh? ___________

I give permission for radiographs (xrays) of clinically necessary.

❑ Yes

❑ Please call prior to taking any radiographs

______________________	____________	____________	______________________
Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history