CIPES PEDIATRIC DENTISTRY

798 Farmington Avenue, West Hartford, CT 06119

PEDIATRIC MEDICAL HISTORY

Patient Name: _____ **D.O.B.:** _____

MEDICAL HISTORY UPDATE (ONLINE/PHONE)

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 know? ☐ YES ☐ NO

Describe:_____

_____

How much does your child weigh? _____

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

❑ Yes

❑ Please call prior to taking any radiographs

Best phone # to reach you during appointment: _____

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

_____
Signature of Doctor reviewing history