dental aid
because everyone deserves dental health
www.dentalaid.org

MEDICAL-DENTAL HISTORY

CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____

SOCIAL SECURITY #: _____ SEX OF PATIENT: MALE/FEMALE

Has your child ever experienced an unusual or allergic reaction to any of the following?

Yes	No		Staff Notes Only
		Latex (like balloons)	
		Penicillin or other antibiotics	
		Codeine or other narcotics	
		Local Anesthesia	
		Food or other:	

Has your child ever had any of the following?

Yes	No		Staff Notes Only
		Heart Murmur	
		Congenital Heart Disease	
		Asthma, Cystic Fibrosis, Respiratory	
		Jaundice, Hepatitis, Liver Disease	
		Diabetes, Thyroid, Endocrine problem	
		Kidney Disease	
		Neurologic Disease, Cerebral Palsy, Seizures	
		Sexually Transmitted Disease	
		HIV/AIDS	
		Anemia, hemophilia, blood/bleeding disorders	
		Sickle Cell Disease or Trait	
		Cancer	
		Speech Disorder	
		Hearing Disorder	
		History of Premature Birth	
		Sight or Eye Disorder	
		Mental or Developmental Delay	
		Has your child ever received blood or blood products?	
		Has your child ever been hospitalized?	
		Has your child ever been seriously ill?	
		Has your child ever had surgery?	
		Pain in teeth	
		Swelling of the mouth	
		Injury to teeth or face	

dental aid
because everyone deserves dental health
www.dentalaid.org

Yes	No		Staff Notes Only
		A bad dental experience	
		Does your water have fluoride?	
		Does your child suck his/her thumb?	
		Any other dental conditions?	
		Is there any other disease or medical condition we should know about?	

Does your child take any medication? YES/NO
What type? _____

Please answer the following for adolescent patients:
Could your child be pregnant? YES/NO
If yes, how many weeks? _____

Is your child currently using any tobacco products? YES/NO
If yes, what type(s)? _____

Is your child currently using alcohol or street drugs? YES/NO
If yes, what type(s)? _____

Please indicate the name, address and telephone number of your child's primary care physician
Physician: _____
Address: _____
Phone: _____

INSURANCE INFORMATION
Medicaid: Yes/No Medicaid Number: _____
CHP+: Yes/No Plan Number: _____
Delta Dental: Yes/No Plan Number: _____ ID #: _____
Other Insurance: Yes/No Plan Number: _____ ID #: _____
Insurance Company Name and Address: _____
_____

In order to provide the best care for your child, today's visit may include diagnostic dental radiographs (x-rays), professional cleaning, fluoride treatment and comprehensive examination. By signing below I indicate I understand and give my consent.

Signature: _____ Date: _____

Relationship to patient: _____

Reviewed by: _____ Date: _____

LOUISVILLE: 877 South Boulder Road, Louisville, CO 80027 • 303.665.8228
BOULDER: 4155 Darley Avenue, Boulder, CO 80305 • 303.499.7072
LONGMONT: 1715 Princess Drive, Longmont, CO 80501 • 303.682.2619