FIRESTONE PEDIATRIC DENTISTRY & ORTHODONTICS

MEDICAL HISTORY □ UPDATE

Patient Information *(Información del Paciente)*

1 Has either parent had orthodontic treatment? YES or NO

2. Have you had other Orthodontic Consults or Treatment? YES or NO

If so, Where have you received other Orthodontic Consults or Treatment?_____

3. Are you satisfied with past orthodontic treatment? YES or NO

Medical History (*Historial Médico)*

4. Have there been any injuries to the face, mouth, teeth?

If so, describe injuries_____

5. Have you experienced (check ones that apply):

□ Automobile accident □ Bleed/Clotting Problems
□ Accidental Injury □ Major/Minor surgery
□ Blood transfusion □ Hyperactivity

6. Do you have a personal physician? YES or NO

7. Are you currently under the care of a doctor other than regular check-ups? YES or NO

If yes, please explain: _____

8. Do you require premedication for dental treatment? YES or NO

9. Do you have a latex allergy/sensitivity? YES or NO

10. Please list any alleries or drug sensitivity: _____

11. Are you taking any prescription drugs? YES or NO

If yes, please list: _____

Medical Information, Have you ever been diagnosed or treated for (please check any that apply):

□ History of major illness
□ Frequent colds
□ Sore throats
□ Ear infections
□ Frequent sinusitis
□ Allergies
□ Autoimmune disease
□ Blood disorder
□ High blood pressure
□ Low blood pressure
□ Smoker
□ Epilepsy
□ Diabetes
□ Asthma

12. Please list any other contributing medical history:_____

For women only(If male skip to 16)

13. When was your first menstrual cycle?

14. Are you pregnant? YES or NO

15. Are you nursing? YES or NO

(Continued on reversed side)

Patient Dental History (*Historia Dental)*

16. How frequently do you have dental check-ups?

□ Twice a year □ Once a year

□ Only for emergencies □ Never

17. When was patients last dental check-up? _____(Month/Year)

18. Do you brush your teeth daily? YES or NO

19. Do you floss teeth daily? YES or NO

20. Do you use Supplemental Mouth Rinses? YES or NO

21. Who is your general dentist?_____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in mine or my child's medical status. I also authorize the dental staff to perform the necessary dental services.

X_____ _____

Signature of Patient / Parent / Guardian Date Relationship to Patient

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

X_____

Signature of Doctor

Doctor Comments: