Portsmouth Pediatric Dentistry

Office Use Only

Name: ______________________________ DOB: ____________ Today's Date: ____________
First Middle Int Last

Any dental concerns for today? ____

- Apporximate weight of your child __________________LBS
- Is a physician treating your child presently for a specific illness? Y N
  If so, please explain ____
- Is your child taking any medications at this time? Y N

Drug	Dose	Frequency	Reason

- Is your child up to date on all of his/her immunizations? Y N
- Has your child taken any unusual medications in the past? Y N
  If so, please explain ____
- Has your child had any allergic reactions to medications or food? Y N
  ____
- Has your child ever been hospitalized or had any operations? Y N
  If so, please explain ____
- Does your child have any history of any of the following conditions? Check if yes.

__ ADD or PDD	__ Diabetes	__ Liver Disease	__ Aids or HIV
__ Down Syndrome	__ Rheumatic Fever	__ Anemia	__ Emotional Problems
__ Seizures	__ Asthma	__ Hearing Problems	__ Sickle Cell Disease
__ Autism	__Speech Problems	__ Bleeding Disorder	__ Heart Murmur/Defect
__ Tuberculosis	__ Cancer/Leukemia	__ Kidney Disease	__ Vision Problems
__ Cerebral Palsy	__ Latex Allergy	__ Sensory Issues	__ Cystic Fibrosis
			__ Learning Problems

Signature ______________________________ Relationship to patient ________________

Do we have your permission to contact you through email/text message to confirm appointments? ***___Yes ___No***

Adolescent Section (13 and older)

Although dental personnel treat the area in and around the mouth, the mouth is part of your entire body. Health conditions or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Is your child taking oral contraception? Y N   Is your child pregnant? Y N

Does your child use Tobacco? Y N