Morristown Family Dentistry

Child /Youth Form

Patient Name _____ Preferred Name_____
First Middle Last

SS#_____ Birthdate_____ Age_____ Sex: M or F

Home Address_____ Zip _____

E- Mail Address _____ Referred By _____

Parent/Guardian Name _____ Contact # _____ Relationship _____

Parent/Guardian Name _____ Contact # _____ Relationship _____

Preferred contact (please circle) text email call Dental Insurance YES NO Insurance Company _____

Policy Holder Name, DOB, Social Security Number _____

Reason for visit _____ Date of last cleaning _____

Do you have or have had any of the following conditions?

Acid Reflux……..... Yes No
ADHD……..... Yes No
Arthritis……..… Yes No
Artificial Joints…….....Yes No
(Replacement Date and Type_____)
Asthma……..... Yes No
(Do you carry an inhaler? _____)
Autism…… Yes No
Cancer……..……..…….. Yes No
(Diagnosis Date and Type:_____)
Cardiovascular disease……..……..Yes No
Celiac Disease……..…….……..Yes No
Congenital heart lesions……..… Yes No
Diabetes……..…. Yes No
Eating Disorder……..……. Yes No
Fainting spells or seizures…..……..…. Yes No
Hay fever……......……..Yes No
Hepatitis, jaundice or liver disease…. Yes No
High Blood Pressure……..……. Yes No
HIV/AIDS……..…….. Yes No
Low Blood Pressure……..……..Yes No
Psychiatric counseling……..…….. Yes No
Rheumatic fever ……..…. Yes No
Serious head, neck, or jaw injury……...Yes No
(Date and Type:_____)
Sleep Apnea……...…… Yes No
(Do you wear a CPAP?_____)
Tobacco use……..…….. Yes No
Substance abuse (alcohol, drugs)…….. Yes No
Venereal disease……..……..Yes No
Mitral Valve Prolapse……..……. Yes No

Describe any other major illness or injury not mentioned _____

_____

_____

Have you ever experienced abnormal bleeding following a cut or extraction? Yes No
If so, explain_____

Females: Are you taking birth control..... Yes No

Are you currently or could possibly be pregnant? Yes No

Are you **currently** taking**:**

Antibiotics..... Yes No
Anticoagulants or blood thinner..... Yes No
High blood pressure medication ..... Yes No
Cortisone, steroids or ACTH..... Yes No
Sleep medication..... Yes No
Insulin ..... Yes No
Tranquilizers or sedatives ..... Yes No

Have you been told by a doctor that you are required to take antibiotics prior to treatment?..... Yes No

List all current medications (including any over the counter):

_____

_____

_____

Preferred Pharmacy:

_____

_____

Are you **ALLERGIC TO** or have you reacted adversely to?

Anticoagulants or blood thinner..... Yes No
Aspirin…… Yes No
Barbiturates, sedatives or sleeping pills..... Yes No
Codeine…… Yes No
Iodine……..... Yes No
Latex…… ..... Yes No
Local anesthetics……. Yes No
Nickel ..... Yes No
Penicillin ..... Yes No
Other_____

I hereby consent to all visits necessary for _____ to receive an oral evaluation, dental treatment and maintenance treatment and for the release of information of health conditions to official agencies and/or private doctors. To the best of my knowledge, the medical history is true and accurate. I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

SIGNATURE_____Date _____

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