NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心

NEMS MRN:

NAME:

Date of Birth:

DENTAL HISTORY FOR PEDIATRIC PATIENTS

If you are a parent or guardian, please answer the following questions on behalf of the child. If you are a child filling out this form yourself, please answer the questions on your own behalf.

1. Do you have/does the child have or have had		
a. Any particular concerns about his/her/your mouth / teeth / overall oral health? If YES, please describe _____	☐ Yes	☐ No
b. Any problem(s) with dental treatment in the past?	☐ Yes	☐ No
c. Any facial or head injuries?	☐ Yes	☐ No
d. Special dental treatment(s) such as braces, jaw surgery, hospital dentistry, etc.?	☐ Yes	☐ No
e. Pre-medicated with antibiotic before dental appointment in the past?	☐ Yes	☐ No
f. Been shown how to floss or brush?	☐ Yes	☐ No
2. Does the child/do you brush or floss? If YES, how often? _____	☐ Yes	☐ No
3. Has there been any change in the child's or your general health in the last two years?	☐ Yes	☐ No
4. Approximate date of last physical exam?	____/____/____	
5. Is the child/are you now under the care of a physician? If YES, Physician's name: _____	☐ Yes	☐ No
6. Any serious illness, operations, or hospitalizations in the last 5 years? If YES, please describe _____	☐ Yes	☐ No
7. Is the child/are you taking any medication(s)? If YES, please describe _____	☐ Yes	☐ No
8. Is the child/are you allergic or has he/she/you reacted adversely to any medication or food? If YES, please describe _____	☐ Yes	☐ No
9. **PLEASE ANSWER THE FOLLOWING QUESTIONS**		
a. Does the child/do you use tobacco products?	☐ Yes	☐ No
b. Females: Is the child/are you pregnant?	☐ Yes	☐ No

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10. Other Health Problems or Conditions

_____

_____

I HAVE READ AND ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THIS INFORMATION IS NECESSARY TO PROVIDE THE CHILD WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I WILL NOTIFY THIS CLINIC OF ANY FUTURE CHANGES IN THE HEALTH OR MEDICATIONS TAKEN BY THE CHILD.

Signature of Patient or Legal Representative*

Date | Time

Name of Legal Representative

Relationship of Legal Representative

Signature of Witness (Required if patient is unable to sign)

Date | Time