



WELCOME

•Patient Name: _____

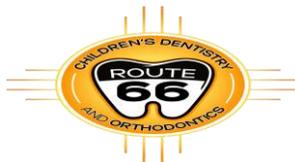
•DOB: _____

• Phone #: _____

Conditions	<p>Does the patient have any MEDICAL CONDITIONS? __YES__ __NO__</p> <p><small>(For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal Allergies, ETC)</small></p>
	<p>If YES, what conditions?</p>
	<p>Does the patient have any HEART conditions? __YES__ __NO__</p> <p><small>(For example: Heart Murmur, congenital Heart Defects, ETC)</small></p>
	<p>If YES, what conditions?</p>
	<p>Does the patient require an ANTIBIOTIC before being seen? __YES__ __NO__</p> <p><small>If YES, did the patient take the antibiotic? __YES__ __NO__</small></p>
	<p>Does the patient have any history of Cancer or Kidney Disease? __YES__ __NO__</p> <p><small>If Yes, please explain:</small></p>
	<p>Is there any possibility of pregnancy? __YES__ __NO__</p>
Allergies	<p>Does the patient have an ALLERGY to LATEX? __YES__ __NO__</p>
	<p>Does the patient have any OTHER ALLERGIES? __YES__ __NO__</p> <p><small>(For example: Animals, Foods, Medications, Nickel, ETC)</small></p>
	<p>If YES, what allergies?</p>
Medications	<p>Is the patient currently taking ANY Medications/Vitamins? __YES__ __NO__</p> <p><small>If Yes, what medications/Vitamins?</small></p> <p><small>Why is the patient taking this medication (what condition is it for)?</small></p>
	<p>Do you (or the patient) have any DENTAL CONCERNS? __YES__ __NO__</p> <p><small>If YES, what concerns do you have?</small></p>
	<p>Has the patient had any surgeries/hospitalizations in the past 2 years? __YES__ __NO__</p> <p><small>If YES, what was the approximate date and reason?</small></p>

UPDATE ADDRESS: _____

LEGAL GUARDIAN: _____



It is important that the medical and dental information provided is current and accurate. In order for our doctors to provide safe and effective dental care, it is necessary for them to know your dental history. Thank you for taking your time to fill out this form completely.

DENTAL HISTORY

Name of Previous Dentist _____ Phone # _____

How long has it been since you've seen a dentist? _____

Reason for your dental visit today _____

Have you had any periodontal (Gum) problems? YES NO

Do your gums bleed or feel irritated or tender? YES NO

Do you floss regularly? YES NO

Do you have headaches, earaches or neck pain? YES NO

Have you worn braces on your teeth? YES NO

Are you happy with the appearance of your teeth? YES NO

If not, please explain _____

Are your teeth sensitive to (please circle) HOT SWEETS

COLD PRESSURE

I certify that the information I have given is correct to the best of my knowledge. If any changes do occur I will notify Route 66 Children's Dentistry and Orthodontics and update my file.

Signature: _____ Date: _____