BOTHELL PEDIATRIC DENTISTRY

SPECIALISTS IN INFANTS, CHILDREN & ADOLESCENTS

18807 Beardslee Blvd Suite 103, Bothell, WA 98011 425.486.6300

PATIENT MEDICAL/DENTAL HISTORY

Name ______________________________ Preferred Name ______________ Date of Birth _____________ Boy/Girl

Brothers, Sisters ____

MEDICAL INFORMATION

Child's Physician ____ Phone # _______________________

Is your child taking any medications? Y / N   Please list ____

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Does your child have any allergies or drug sensitivities? _______ Please describe ___________________________

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Please check any of the following conditions for which your child has been treated

- ☐ Asthma or Airway/Lung Issues
- ☐ Autism
- ☐ Bleeding Disorder/Anemia
- ☐ Behavioral Diagnosis (i.e. ADD/ADHD)
- ☐ Cancer or any other tumor
- ☐ Cerebral Palsy
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ GERD/Nutritional Concerns
- ☐ Genetic Concerns (i.e. MTHFR gene mutation)
- ☐ Heart Disorder/Defect or Murmur
- ☐ Hepatitis
- ☐ Liver/Kidney Disorders
- ☐ Silver Allergy
- ☐ Speech/Hearing/Vision Problems
- ☐ Other

Please describe ____

Has your child ever been hospitalized or required surgery? Y / N   Please describe __________________________

DENTAL INFORMATION

Please describe your main concern about your child's dental health _____________________________________

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Has your child had a negative experience in the past with a dentist or physician? __________ Please explain ______________

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Parent/Guardian Signature ____ Date_____________________