CACHE VALLEY PEDIATRIC DENTISTRY

DAREN F. GEHRING, DDS
1624 North 200 East, Suite 100
Logan, UT 84341
Phone: (435) 752-4330

MEDICAL HISTORY FORM

CHILD'S NAME _____
First Name Middle Initial Last Name

MEDICAL HISTORY

Does your child see a physician regularly? ◯ Yes ◯ No If yes, please list physician's name and reason(s) for visits. _____

Please list any medications that your child is currently taking & the reason(s) for taking them. _____

Does your child have any allergies to certain medications? ◯ Yes ◯ No If Yes, please list: _____

Does your child have other allergies? ◯ Yes ◯ No If Yes, please list: _____

Has your child had any serious illnesses? ◯ Yes ◯ No If Yes, please list: _____

Has your child ever had major surgery or been hospitalized? ◯ Yes ◯ No If Yes, please explain: _____

PLEASE INDICATE YES OR NO TO WHETHER OR NOT YOUR CHILD HAS HAD, OR CURRENTLY HAS ANY OF THE FOLLOWING CONDITIONS.

ADD/ADHD	◯ Yes	◯ No
Asthma, TB or Lung Problems	◯ Yes	◯ No
Autism	◯ Yes	◯ No
Cancer, Tumor or Leukemia	◯ Yes	◯ No
Cerebral Palsy or Developmental Delay	◯ Yes	◯ No
Cleft Lip or Palate	◯ Yes	◯ No
Congenital Birth Defects	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Down Syndrome	◯ Yes	◯ No
Emotional or Psychological Problems	◯ Yes	◯ No
Epilepsy, Seizures or Fainting	◯ Yes	◯ No
Heart Trouble, Murmur or Surgery	◯ Yes	◯ No
Hemophilia or Bleeding Problems	◯ Yes	◯ No
Hepatitis or Liver Problems	◯ Yes	◯ No
HIV Infection or AIDS	◯ Yes	◯ No
Kidney Infection	◯ Yes	◯ No
Latex or Rubber Allegry	◯ Yes	◯ No
Malignant Hyperthermia	◯ Yes	◯ No
Radiation Treatment	◯ Yes	◯ No
Rheumatic Fever or Scarlet Fever	◯ Yes	◯ No
Sickle Cell Anemia/Blood Disorder	◯ Yes	◯ No
Speech or Hearing Problem	◯ Yes	◯ No
Thyroid or Other Glandular Problems	◯ Yes	◯ No
Vision Problems	◯ Yes	◯ No
Williams Syndrome	◯ Yes	◯ No

Other Medical Conditions: _____

FLUORIDE TREATMENT

At the recommendation of the American Academy of Pediatric Dentistry, our standard is to apply fluoride to your child's teeth at every 6 month appointment. Some insurances will only allow this treatment to be paid once per year.

◯ Please apply fluoride at every cleaning
- I will be responsible for the charge allowable by my insurance when it is not covered.

◯ Please only apply fluoride when it is paid by my dental insurance.

COMMENTS *(Office Use Only)*

DENTAL HISTORY

When and where was your child's last dental visit?

When _____ Where _____

What was the purpose of their last visit? _____

Phone number of your child's last dentist (_____) _____

Were any x-rays taken at their last visit?	○ Yes	○ No
Did your child have a difficult time cooperating?	○ Yes	○ No
Was/is your child bottle fed?	○ Yes	○ No
Was/is your child breast fed?	○ Yes	○ No
Do you assist/supervise your child's brushing?	○ Yes	○ No
Does your child take fluoride supplements?	○ Yes	○ No
Have any cavities been noted in the past?	○ Yes	○ No
Has there been any injury to your child's teeth? (falls, blows, chips, etc.)	○ Yes	○ No

If answer is yes, please explain: _____

Has your child had a toothache recently?	○ Yes	○ No
Do you expect your child to be cooperative?	○ Yes	○ No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. Gehring and his staff to perform such treatment, services, medications, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality and/or infection.

_____ _____

Signature of Parent/Guardian Date