Fox Kids
DENTISTRY & ORTHODONTICS

Patient Medical Health History

Patient Name: _____ Date of Birth: _____

Patient's Pediatrician/Physician: _____ Practice Name: _____

Current medications: ☐ None ☐ List: _____

Allergies (food/drug/latex): ☐ None ☐ List: _____

Has the patient ever had any of the following conditions?

Asthma	Y	N	High or low blood pressure	Y	N
Abnormal Bleeding/Bruising	Y	N	Hepatitis/Liver Conditions	Y	N
Acid Reflux/GI Problems	Y	N	HIV/AIDS	Y	N
ADD/ADHD	Y	N	Immune Disorders	Y	N
Artificial Joints or Heart Valves	Y	N	Intellectual Disability	Y	N
Autism	Y	N	Kidney Problems	Y	N
Blood Disorders	Y	N	Organ transplant	Y	N
Cancer	Y	N	Any Operations	Y	N
Congenital Birth Defects	Y	N	Physical Handicaps/Disabilities	Y	N
Congenital Heart Defects	Y	N	Seizures/Epilepsy	Y	N
Diabetes	Y	N	Sickle Cell Anemia	Y	N
Eating Disorder	Y	N	Snoring/Sleep Apnea	Y	N
Fainting spells	Y	N	Tonsils/Adenoids removed	Y	N
Hearing Impairment	Y	N	Tuberculosis	Y	N

Please elaborate on any of the above or list any other health problems/special concerns: _____

_____

Patient Dental History

Age of 1st dental visit: _____ Previous Dentist/Office Name (if applicable): _____

Is the patient taking supplemental fluoride tablets/drops?	Y	N	
Is the patient interested in braces or Invisalign?	Y	N	
Has your child been seen by an orthodontist previously?	Y	N	With whom: _____
Has your child had his/her wisdom teeth removed?	Y	N	Date of removal: _____

Additional comments regarding your child's dental history: _____

_____

I have read and understand the above questions and have answered them to the best of my ability. If there are any changes to the patient's health status, I will inform the dentist and staff.

Parent/Guardian Signature: _____ Date: _____

Print name: _____

Doctor Signature: _____ Date: _____

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