Shawnee Dental

Eaglesoft Medical History(Child)1

Patient Name: Birth Date: Date Created:

Do You Have a Nickname? Yes No If yes

Fathers Name and occupation Work Number omment

Mothers name and Ocupation Work Number omment

Child's Physician Phone Number omment

Date of last Physical Exam omment

Has child ever had a reaction to any of the following?:

- Penicillin
- Codeine
- Local Anesthesia
- Other?
- Aspirin

Medications Regulary taking:

Has Child ever had any of the following?

- Asthma
- Hepatitis A
- Anaphylaxis
- Diabetes
- Hepatitis B or C
- Epilepsy or Seizures
- Heart Murmur
- Hives or Rash
- AIDS/HIV Positive
- Breathing Problems
- Chemotherapy
- Hay Fever
- Tonsillitis
- Tuberculosis
- Cold Sores/Fever Blisters
- Excessive Bleeding
- Tumors or Growths
- Congenital Heart Disorder
- Psychiatric Care
- Speech Impediment
- Learning Disabilities

Is the Child currently treated by Physician, or Have they ever had any serious illness not listed above? Yes No If yes

Child's Interest and Hobbies:

Change in Privacy Practices, Access to Records(HIPPA)

I would like to add or remove the following person(s) access to these records: omment

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:____________

PEDIATRIC DENTISTRY
RISK ASSESSMENT

Child's Name________________________________ Date_____________________

Child's Age__________________________________ Birth Date________________

To help us assess your child's dental needs, please answer these questions. Thank you.

HEALTH HISTORY	**Yes**	**No**
Did birth mother have any problems during pregnancy?	☐	☐
Has your child needed frequent use of liquid medication?	☐	☐
Has the patient's caretaker seen a dentist in the last year?	☐	☐
Notes:____		
DIET AND NUTRITION		
Is/was your child breastfed?	☐	☐
Does your child sleep with a bottle?	☐	☐
Does your child drink from a sippy cup or cup?	☐	☐
Is your child on a special diet?	☐	☐
Notes:____		
FLUORIDE ADEQUACY		
Do you have well water?	☐	☐
If yes, has the water been tested for fluoride content?	☐	☐
Notes:____		
ORAL HABITS		
Does your child have any oral habits?	☐	☐
Notes:____		
ORAL DEVELOPMENT		
Does your child have teeth?	☐	☐
Child's age (in months) when first tooth erupted?_____________		
Has your child experienced teething problems?	☐	☐
Notes:____		
ORAL HYGIENE		
Do you clean your child's teeth/gums?	☐	☐
Does your caretaker clean your child's teeth/gums?	☐	☐
Do you use a toothbrush to clean your child's teeth?	☐	☐
Do you use toothpaste to clean your child's teeth?	☐	☐
Do you, your significant other/caretaker have untreated dental needs? If yes, who? ___________________________________	☐	☐
Notes:____		

Circle: Mother Father Guardian Signature:__________________________