CDA of Hamden, P.C.

MEDICAL & DENTAL HISTORY

FULL PATIENT NAME:_____

M / F (circle one) DOB: ____/____/_____ Age:_____

Pediatrician Name: _____

Pediatrician Address: _____

Pediatrician Phone #:_____**Date of Last Physical** ____/____/_____

Is Patient **Under Treatment of a Medical Specialist**? Yes / No

Specialist Name:_____

Specialist Address:_____

Specialist Phone #:_____ Are Child's Vaccinations Current? Yes / No

Does Child **Require Pre-Medication Prior to Treatment**? Yes / No

Describe **Any Serious Medical Problem, Hospitalizations, Surgeries, ER Visits &/or Significant Illness or Injury Child has Experienced**: _____

_____

_____

_____

LIST ALL MEDICATIONS Child is Currently Taking, Including Rx and Over Counter— Include **NAME, DOSE & FREQUENCY GIVEN** (Continue on reverse if needed).

NOTE UNFAVORABLE/ADVERSE REACTION(S) TO MEDICATIONS IN DETAIL:

_____

_____

_____

_____

Is This Child's **FIRST DENTAL CARE VISIT?** Yes / No Previous Dentist (Name & Location):_____

Date Last Visit: ____/____/_____ Date Last X-Rays ____/____/_____

Recently Experienced Dental Pain? Yes / No Describe: _____

Injury/Trauma: Yes / No Describe:_____

BRUSHING & FLOSSING: Yes / No FREQUENCY: _____

FLOURIDATED WATER IN HOME? Y / N **SUPPLEMENTS PRESCRIBED?** Y / N

IF YES, DOSE OF _____TABLETS / _____ DROPS GIVEN PER_____.

DOES CHILD HAVE: **Nail Biting Habit** Yes / No **Bleeding Gums** Yes / No

Taste / Light Sensitivity Yes / No **Severe Gag Reflex** Yes / No

Mouth Breathing, snoring, jaw pain/popping Yes / No **Decay** Yes / No

Family History of Cavities/Other Dental Issues? Yes / No Describe:

Authorization & Release: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information is dangerous to my child's health, and that is my responsibility to inform the dental office of changes in my child's medical status. I also authorize CDA dental staff to perform the necessary dental services my child may need, and the release of any information, including diagnosis and records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners involved in the child's dental care. I authorize my insurance company to pay directly to CDA group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or to my dependents.

_____ ____/____/_____

Signature of Patient or Parent (if < 18 years old) Date

Dentist's Notes:

If child has a history of condition listed Circle Y (Yes), if not, Circle N (No)

Y / N	HIV +
Y / N	ADD/ADHD
Y / N	Anemia
Y / N	Allergy/Asthma
Y / N	Autism Spectrum Disorder
Y / N	Behavioral Problems
Y / N	Birth Complications
Y / N	Bleeding Disorder
Y / N	Bone Marrow/Organ Transplant
Y / N	Brain Injury/Epilepsy
Y / N	Bronchitis/Pneumonia
Y / N	Cancer/tumor/malignancy
Y / N	Cerebral Palsy
Y / N	Cleft Lip/Palate
Y / N	Communicable Disease
Y / N	Convulsions/ Seizures
Y / N	Cystic Fibrosis
Y / N	Cytomegalovirus (CMV)
Y / N	Developmental Delay
Y / N	Diabetes
Y / N	Drug/ Alcohol Abuse
Y / N	Endocrine/Growth Disorder
Y / N	Fainting/Dizziness
Y / N	Hearing Loss/Impairment
Y / N	Hemophilia/easy bruising
Y / N	Hepatitis/Jaundice/Liver Probs.
Y / N	High Blood Pressure
Y / N	Hydrocephaly
Y / N	Intellectual Disability
Y / N	Irregular Heartbeat
Y / N	Leukemia
Y / N	Measles
Y / N	MRSA
Y / N	Mumps
Y / N	Pregnancy
Y / N	Psychiatric Disorder
Y / N	Rheumatic Fever
Y / N	Scarlet Fever
Y / N	STD
Y / N	Scoliosis
Y / N	Sickle Cell Anemia/trait
Y / N	Sinus/Snoring Problems
Y / N	Sore Throat (frequent)
Y / N	Spina Bifida
Y / N	Tobacco Smoke Exposure
Y / N	Tonsils/Adenoids Enlarged
Y / N	Transfusions
Y / N	Tuberculosis (TB)
Y / N	Thyroid/Pituitary Issues
Y / N	Transfusions/blood products