WE SMILE DENTISTRY
DR. GIULIO SPAGNUOLO

Medical History (Child)

Patient Name *

First Name Last Name

Date *

Month Day Year

Address *

Street Address

City

Postal / Zip Code

Child's Nick Name

Sex *

School

Name of hobby, sport, toy or playmate special to your child

Does child live with both parents? *

◯ Yes ◯ No

If not, with whom? *

◯ Mother?
◯ Father?
◯ Guardian?

Parents/Guardian email *

example@example.com

Parent / Guardian Complete Name

First Name Last Name

DOB

Month Day Year

Home Address (If different from child's)

Phone Number

Area Code Phone Number

Occupation

◯ Employed
◯ Student
◯ Other
◯ Homemaker
◯ Retired

Employed by

Address

Street Address

City

Postal / Zip Code

Present Position

How Long?

Work Phone Number

Area Code Phone Number

Does the Parent / Guardian have any Insurance? *

◯ Yes ◯ No

Dental Insurance Company *

Group/Plan Number *

ID Number *

Is there secondary insurance? *

◯ Yes ◯ No

The relationship to the patient

Name

Address

Street Address

City

Postal / Zip Code

Date of birth

Month Day Year

Insurance Company Name

Group Number

Plan Number

Parent / Guardian Complete Name

First Name Last Name

DOB

Month Day Year

Home Address (If different from child's) *

Phone Number

Area Code Phone Number

Occupation

◯ Employed ◯ Homemaker
◯ Student ◯ Retired
◯ Other

Employed by

Address

Street Address

City

Postal / Zip Code

Present Position

How Long?

Work Phone Number

Area Code | Phone Number

Does the Parent / Guardian have any Insurance? *

- Yes
- No

Dental Insurance Company *

Group/Plan Number *

ID Number *

Is there secondary insurance? *

- Yes
- No

The relationship to the patient

Name

Address

Street Address

City

Postal / Zip Code

Date of birth

Month | Day | Year

Insurance Company Name

Group Number

Plan Number

Who is responsible for payment? *

Phone number to call about appointments *

Area Code | Phone Number

From where did you learn about this dental office? *

- Newspaper
- School
- Other
- Work

Referred By

- Another patient / friend
- Another patient / relative
- Dental office doctor or staff member
- Other

Name of the person who referred us:

DENTAL HISTORY

Is this your child's first visit to the dentist? *
- ◯ Yes
- ◯ No

Has your child been having any specific problems? *
- ◯ Yes
- ◯ No

Describe *

Last Dental Visit

Purpose

Last Complete Exam

Has your child experienced any unfavorable reaction from any previous dental or medical care?
- ◯ Yes
- ◯ No

Specify

How would you describe your child's dental health? *
- ◯ Good
- ◯ Fair
- ◯ Poor

Describe *

Do you think your child has the following active dental disease?

Decay *
- ◯ Yes
- ◯ No

Gum Disease *
- ◯ Yes
- ◯ No

Child's Home Care

Brush *
- ◯ Yes
- ◯ No

Floss *
- ◯ Yes
- ◯ No

Other

Do your child's gums ever bleed? *
- ◯ Yes
- ◯ No

How often? *

Bad Breath? *
- ◯ Yes
- ◯ No

Does your child have any bad mouth habits? *
- ◯ Yes
- ◯ No

Specify *

MEDICAL HISTORY
(Confidential. Repeated every 5 years)

Birth Date *
Month Day Year

Doctor's Name
First Name Last Name

Last Physical Exam

Current Age *

Does your child have any medical problems? *
◯ Yes ◯ No

Describe *

Is your child under a doctor's care now? *
◯ Yes ◯ No

If so, for what reason *

Is your child taking any medications? *
◯ Yes ◯ No

Please List *

Does your child have any medical conditions/concerns?
◯ Yes ◯ No

If your answer is 'Yes', check the relevant box/es and provide details.

- ☐ Heart disease
- ☐ Diabetes
- ☐ Typhoid fever
- ☐ Asthma
- ☐ Prolonged bleeding
- ☐ Epilepsy
- ☐ Prosthetic valves/joints
- ☐ Allergy to foods
- ☐ Heart murmur
- ☐ Measles
- ☐ Chicken Pox
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Fainting
- ☐ kidney disease / dialysis
- ☐ Other allergies
- ☐ Rheumatic fever
- ☐ Mumps
- ☐ Tonsilitis
- ☐ Arthritis
- ☐ AIDS
- ☐ Seizures / convulsions
- ☐ Allergy to medications
- ☐ Other
- ☐ High blood pressure
- ☐ Scarlet fever
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Malignancies
- ☐ Psychiatric treatment
- ☐ Anesthetic allergy

Provide details of Heart disease *

Provide details of Heart murmur *

Provide details of Rheumatic fever *

Provide details of High blood pressure *

Provide details of Diabetes *

Provide details of Measles *

Provide details of Mumps *

Provide details of Scarlet fever *

Provide details of Typhoid fever *

Provide details of Chicken Pox *

Provide details of Tonsilitis *

Provide details of Jaundice *

Provide details of Asthma *

Provide details of Tuberculosis *

Provide details of Arthritis *

Provide details of Hepatitis *

Provide details of Prolonged bleeding *

Provide details of Herpes *

Provide details of AIDS *

Provide details of Malignancies *

Provide details of Epilepsy *

Provide details of Fainting *

Provide details of Seizures / convulsions *

Provide details of Psychiatric treatment *

Provide details of Prosthetic valves/joints *

Provide details of kidney disease / dialysis *

Provide details of Allergy to medications *

Provide details of Anesthetic allergy *

Provide details of Allergy to foods *

Provide details of Other allergies *

List all of your child's allergies here: *

AUTHORIZATION: I hereby authorize the doctor and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care of my child as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Signature *

Name *

First Name Last Name

Date *

Month Day Year