Dr. Peter Balega
Family Dentistry

WELCOME

PEDIATRIC FORM

Patient Name: _____Date of birth: _____ Age: _____ ☐ Male ☐ Female

Home Address: _____

City State Zip Code

Father/ Legal Guardian: _____ Date of Birth: _____

Place of Employment: _____ Work #: _____

Cell #: _____ Social Security #: _____

Mother/ Legal Guardian: _____ Date of Birth: _____

Place of Employment: _____ Work #: _____

Cell #: _____ Social Security #: _____

Medical History

1. **Is your child taking any medicines or drugs at this time? (List) _____**

   _____
2. **Has your child had any allergic or unfavorable reactions to any medications, drugs or food? (List)**

   _____

   _____
3. **Has your child ever been hospitalized or seriously injured?**

   _____
4. **Child's Healthcare Physician _____**
5. **Date and reason of last medical exam _____**
6. **Has your child had vaccinations? DPT _____ Polio _____ Etc. _____**
7. **Has your child had or ever been treated for :**

Rheumatic Fever/ Rheumatic Heart Disease	**Yes ( )**	**No ( )**
Heart Murmur	**Yes ( )**	**No ( )**
Congenital Heart Disease	**Yes ( )**	**No ( )**
Excessive Bleeding	**Yes ( )**	**No ( )**
Blood Transfusion	**Yes ( )**	**No ( )**
AIDS	**Yes ( )**	**No ( )**
Sickle Cell Anemia	**Yes ( )**	**No ( )**
Epilepsy/ Convulsions	**Yes ( )**	**No ( )**
Mental or emotional problems	**Yes ( )**	**No ( )**

Liver Disease/ Hepatitis	**Yes ( )**	**No ( )**
Kidney Problems	**Yes ( )**	**No ( )**
Breathing/Lung Problems	**Yes ( )**	**No ( )**
Sinus Problems	**Yes ( )**	**No ( )**
Diabetes	**Yes ( )**	**No ( )**
Arthritis	**Yes ( )**	**No ( )**

8. **If applicable, is your child taking birth control? Yes ( ) No ( )**
9. **If applicable, if your child pregnant? Yes ( ) No ( )**

DENTAL HISTORY

1. **Is your child having any discomfort at this time? _____**
2. **Is this your child's first visit to a dentist? _____**
3. **Has your child had any trouble with dental treatment? _____**
   _____
4. **Has your child had any unfavorable reactions to local anesthetic (Novacaine) ? _____**
5. **Has your child ever had any of the following:**

Injuries to their face or teeth	**Yes ( )**	**No ( )**
Body Injury (neck, back…)	**Yes ( )**	**No ( )**
Pain or noise in the jaw joint	**Yes ( )**	**No ( )**
Frequent sore throats	**Yes ( )**	**No ( )**
Bleeding gums	**Yes ( )**	**No ( )**
Toothaches	**Yes ( )**	**No ( )**
Cold Sores/ Fever Blisters	**Yes ( )**	**No ( )**

6. **Have you noticed your child:**

Sucking their thumb or fingers	**Yes ( )**	**No ( )**
Breathing with their mouth open	**Yes ( )**	**No ( )**
Grinding their teeth	**Yes ( )**	**No ( )**
Using a pacifier	**Yes ( )**	**No ( )**
Using tobacco products	**Yes ( )**	**No ( )**

My signature below indicates that I understand and have answered all questions on the medical and dental health history to the best of my knowledge. I request and freely consent to the performance of procedures which are deemed necessary for my child's dental health care and that these procedure may be discussed with the doctor prior to their taking place.

Parent or Guardian Signature _____

Date: _____