PROVIDENCE Child Center

PATIENT HISTORY FORM

Patient Name ____ Patient's DOB ___________ Sex: M F
Last First MI (please circle one)
Address ____________________________________ City ___________________ ST___ Zip ___________

Primary Phone H / C / W ______________________ Secondary Phone H / C / W ___________________

______________________ Name ________________________ Marital Status: Married / Divorced / Single
(Print Relation to Patient) Phone ________________________ Email ____________________________

______________________ Name ________________________ Marital Status: Married / Divorced / Single
(Print Relation to Patient) Phone ________________________ Email ____________________________

Do these individuals live with the patient? Yes No If No, Who does patient live with? _________________

Patient's Physician Name: _____________________ Last Exam: ________ Phone #: _________________
Physician's Clinic's Name and Address: ____
Pharmacy Name & Location: ____ Phone _________________

Question		
Is the patient in good health?	YES	NO
What is the patients current: Height?: ____________ Weight?: ____________		
Has there been any change in his/her general health within the last year?	YES	NO
Does the have any specified medical conditions/diagnosis'? If yes, specify ____	YES	NO
Is the patient now under the care of a physician? If yes, what is the condition(s) being treated? ________________________________ ____	YES	NO
Has the patient had a serious illness, operation, or been hospitalized in the past 5 years? If yes, what was the illness or problem? ____	YES	NO
Is the patient taking any medicine(s) including non-prescription medicine? If yes, list all medications the patient is taking: Medication___________________________ Dose ___________ Condition ___________ Medication___________________________ Dose ___________ Condition ___________ Medication___________________________ Dose ___________ Condition ___________ Medication___________________________ Dose ___________ Condition ___________ Medication___________________________ Dose ___________ Condition ___________	YES	NO
Does the patient have an arrhythmia or an irregular heart beat?	YES	NO
Has the patient's physician ever instructed him/her to take antibiotics prior to dental therapy for a medical condition? If yes, why?____	YES	NO
Does the patient have/had any of the following diseases or problems? (circle all that apply)		
1.) Knee or hip replacement, plastic or artificial arteries?	YES	NO
2.) Congenital heart defect or murmur?	YES	NO
3.) Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?	YES	NO
4.) Does the patient have inborn heart defects?	YES	NO
5.) Respiratory disease	YES	NO
a.) Asthma, Bronchitis, Pneumonia, Emphysema, Tuberculosis (TB)	YES	NO
b.) Chronic cough	YES	NO
c.) Hay fever, sinus trouble, allergies	YES	NO
d.) Does the patient currently have a cold or the flu?	YES	NO
6.) Diabetes	YES	NO
7.) Persistent diarrhea or recent weight loss	YES	NO
8.) Hepatitis, jaundice or liver disease	YES	NO
9.) AIDS or HIV	YES	NO
10.) Fainting spells or seizures	YES	NO
11.) Thyroid problems	YES	NO
12.) Arthritis or painful swollen joints	YES	NO
13.) Stomach ulcer or hyperacidity	YES	NO
14.) Kidney trouble	YES	NO
15.) Persistent swollen glands in neck	YES	NO

16.) Low blood pressure	YES NO
17.) Epilepsy or other neurological disease	YES NO
18.) Problems with mental health If yes, specify ____	YES NO
19.) Cancer	YES NO
20.) Problems of the immune system	YES NO
21.) Has the patient had any serious trouble associated with any previous dental treatment, surgery or any previous anesthetic? If yes, explain ____	YES NO
22.) Has anyone in your family had a bad reaction to any anesthetic? If yes, explain ____	YES NO
23.) Is the patient wearing contact lenses?	YES NO
Does the patient bleed easily, bruise easily or have you had abnormal bleeding with previous treatment?	YES NO
Does the patient have any blood disorder such as anemia?	YES NO
Has the patient had surgery or x-ray treatment for a tumor, growth of your head or neck?	YES NO
Is the patient allergic or has he/she reacted adversely to: ○ Local anesthetics ○ Valium ○ Advil ○ Aspirin ○ General anesthetics ○ Demerol ○ Ibuprofen ○ Morphine ○ Sulfa drugs ○ Codeine ○ Iodine ○ Penicillin ○ Barbiturates ○ Sleeping Pills ○ Sedatives ○ Other antibiotics ○ Foods ○ Other ___________________________	YES NO
Why have you brought your child to visit us today? ________________________________	
When was your child's last dental visit? Date: ______________ Were X-rays taken?:	YES NO

I understand that withholding any information about the patient's health could seriously jeopardize his/her safety. Therefore, I have reviewed this health history carefully and have answered all questions truthfully to the best of my knowledge.

____ ________________________

Signature of Patient or Guardian (if minor) **Date**

In the event of an emergency please contact:
Name______________________________ Relationship_____________________ Phone _____________
Name of nearest relative not living with child ______________________________ Phone _____________

Medical health reviewed by:	If patient is a minor:
X______________________________ Doctor's Signature and Date	X______________________________ Parent/Guardian's Signature and Date
X______________________________ Doctor's Signature and Date	X______________________________ Parent/Guardian's Signature and Date
X______________________________ Doctor's Signature and Date	X______________________________ Parent/Guardian's Signature and Date
X______________________________ Doctor's Signature and Date	X______________________________ Parent/Guardian's Signature and Date

Power of Attorney

I, the undersigned, hereby authorize ____
to bring in ____ to receive dental treatment.

Signature of Parent or Guardian X__________________________________ Date ___________________

I give permission to Providence Specialty Pediatric Dental Clinic to administer any necessary treatment in the event of a medical emergency.
Signature of Parent or Guardian X__________________________________ Date ___________________

Case Worker Information

Name: _____________________________ Office Name: ____________________________________
Phone #: __________________________ Fax #: ___________________________
Address: ____
Is the Caseworker the legal guardian: Yes or No
If no, who is the Patient's legal guardian?: ____