

II. Medical History

Does your child have a history of any of the following? Please circle.

YES	NO	Allergies	YES	NO	Hearing/Speech Disorder
YES	NO	Asthma	YES	NO	Heart Disease
YES	NO	Autism	YES	NO	Heart Murmur
YES	NO	Bleeding Disorders	YES	NO	Hepatitis
YES	NO	Bronchitis	YES	NO	Hyperactivity or ADHD
YES	NO	Cancer/Tumors	YES	NO	Jaundice
YES	NO	Cerebral Palsy	YES	NO	Kidney or Liver Disease
YES	NO	Cleft Lip/Palate	YES	NO	Lung Problems
YES	NO	Diabetes	YES	NO	Mental Disorder
YES	NO	Ear Infections	YES	NO	Nervous Disorder
YES	NO	Ear Tubes	YES	NO	Rheumatic Fever
YES	NO	Epilepsy	YES	NO	Seasonal Allergies
YES	NO	Eyes or Eyesight Disorder	YES	NO	Seizures
YES	NO	Fainting	YES	NO	Sickle Cell Disease/Trait
YES	NO	Feeding/Eating Problems	YES	NO	Sleep Apnea
YES	NO	Gastrointestinal Disorder	YES	NO	Spina Bifida
YES	NO	HIV	YES	NO	Sensory Integration Disorder

Other physical or medical disorders: _____

YES NO Has any immediate family member had any of the above? If "yes," please describe: _____

YES NO Were there any difficulties during pregnancy, delivery, or the first year of the child's life? If "yes," please explain: _____

YES NO Was birth premature? If "yes," please explain: _____

YES NO Has your child ever had general anesthesia? If "yes," please explain: _____

YES NO Has your child ever been hospitalized? If "yes," please explain: _____

YES NO Is your child *currently* taking any medications? If "yes," please list medication and dosage: _____

Has your child had any *allergic reactions* to:

YES NO Medications or drugs {such as penicillin, aspirin, or lidocaine (local anesthetic)}?

YES NO Latex?

YES NO Foods?

YES NO Food coloring/additives?

If "yes," please list and describe reaction: _____

YES NO Have you ever been informed that your child needs to take *antibiotics prior to dental treatment*?

If "yes," please explain: _____

YES NO Would you consider your child to be in good health at the present time?

If "no," please explain: _____

Date of last physical examination by pediatrician/physician? _____

YES NO Are your child's immunizations current?

III. Dental History

What is your main concern about your child's dental health?

YES NO Is this your child's first visit to the dentist?

If "no," date of last dental visit ____/____/____ Service performed: _____

YES NO Have X-rays been taken?

YES NO Has your child ever complained about a dental problem or had any unhappy dental experiences?

Please explain:

YES NO Was your child breast-fed? If "yes," for how long? _____

YES NO Was your child bottle-fed? If "yes," for how long? _____

YES NO Sleeps or slept with bottle/sippy cup?

Did your child get his/her teeth... please circle one: EARLY ON TIME LATE

Does (did) your child have any of the following habits?

YES	NO	Thumb/Finger sucking	YES	NO	Pacifier sucking
YES	NO	Nail biting	YES	NO	Night time grinding
YES	NO	Mouth breathing			

Please circle if your child has/had/or may have ANY of the following dental problems:

YES	NO	Cavities	YES	NO	Teeth bumped or chipped
YES	NO	Teeth sensitive to sweets	YES	NO	Discoloration of teeth
YES	NO	Teeth sensitive to hot/cold	YES	NO	Cold sores/fever blisters/mouth ulcers
YES	NO	Gum infection/abscess	YES	NO	Pain and/or noise with opening

Is there anything else you would like us to know regarding your child's dental health history?

Who brushes your child's teeth? please circle: CHILD CHILD AND PARENT PARENT

How often are your child's teeth brushed? _____

YES NO Is your home water supply fluoridated?
YES NO Is the water fluoridated where your child spends the day?
YES NO Does your child use a fluoride toothpaste?
YES NO Has your child had any other form of fluoride?

Has your child inherited any dental conditions? Please describe below:

How are YOUR own teeth? (Cavities, braces...) _____

How do you expect your child to behave in our office? _____

If there is any information that you feel might be of value to us in the treatment of your child, please add it here:

Please read and initial the following statements:

_____ I affirm that the information given above is correct to the best of my knowledge. It is my responsibility to inform Chapel Hill Pediatric Dentistry of any changes to my child's medical status.

_____ I have the right to access the Notice of Privacy Practices at any time. The Notice of Privacy Practices provides a description of our treatment, payment activities, healthcare operations, and the uses/disclosures we may make of your protected health information.

_____ I have understood the financial policy of Chapel Hill Pediatric Dentistry.

_____ Your scheduled appointment has been reserved just for you. Obviously any change in this appointment affects another child who is waiting for a scheduled appointment. If you must cancel, we need to know at least 24 hours in advance. If 24 hour notice is not given, there will be a charge.

_____ I request and authorize Dr. Rampersaud, Dr. Prada, and Associates of Chapel Hill Pediatric Dentistry to provide dental treatment for my child. I understand the dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age.

Because your child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before Dr. Rampersaud, Dr. Prada, and Associates can initiate and provide any dental treatment.

Signature _____ Date ____/____/____



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