Division Of Public Health Dental Clinics
Medical/Dental History

Patient's Name: _____ Sex: _____ Date of Birth: _____ Age: _____

Medicaid # _____ Social Security #_____ School: _____ Grade: _____

Home Address: _____ City/town: _____ Home Phone #: _____

Parent/Guardian's Name: _____ Cell Phone # _____ Work Phone #: _____

Emergency Contact's Name: _____ Phone # _____

Physician's Name: _____ Phone # _____

Reason for Today's Visit: _____

Have you (parent/guardian) or the child had any of the following: (1) Active Tuberculosis (2) Cough with blood (3) Cough lasting longer than three weeks?
If yes, please stop and return form to receptionist

Check the box if the child has a history of or difficulty with any of the following:

☐ **Anemia**	☐ **Cancer**	☐ **Fainting**	☐ **Immunization**	☐ **Mononucleosis**	☐ **Thyroid**
☐ **Arthritis**	☐ **Cerebral Palsy**	☐ **Growth Problems**	☐ **Kidney**	☐ **Mumps**	☐ **Tobacco/Drug Use**
☐ **Asthma**	☐ **Chicken Pox**	☐ **Hearing**	☐ **Latex Allergy**	☐ **Pregnancy**	☐ **Tuberculosis**
☐ **Bladder**	☐ **Sinusitis**	☐ **Heart**	☐ **Liver**	☐ **Sickle Cell**	☐ **Venereal Disease**
☐ **Bleeding Disorder**	☐ **Diabetes**	☐ **Hepatitis**	☐ **Mastoiditis**	☐ **Seizures**	☐ **Other** _____
☐ **Bones/Joints**	☐ **Epilepsy**	☐ **HIV/AIDS**	☐ **Measles**	☐ **Rheumatic fever**	

Child's Medical History

	Yes	No	
Does the child currently have any illnesses?	☐	☐	If yes, what? _____
Has the child's general health changed in the past year?	☐	☐	
Is the child taking any medications at this time?	☐	☐	If yes, please list. _____
Is the child allergic to latex?	☐	☐	
Is the child allergic to any medications such as penicillin?	☐	☐	If yes, list medications. _____
Has the child ever had a serious illness?	☐	☐	If yes, what? _____
Has the child ever been hospitalized?	☐	☐	If yes, for what? _____
Does the child have any inherited conditions?	☐	☐	If yes, what condition? _____
Does the child have any speech difficulties?	☐	☐	
Has the child ever had a blood transfusion?	☐	☐	If yes, when? _____
Is the child physically, mentally, or emotionally impaired?	☐	☐	

Child's Dental History

	Yes	No		Yes	No
Is this the first visit for the child to the dentist?	☐	☐	If no, list date of last visit. _____		
Has the child had dental X-rays before?	☐	☐	If yes, when? _____		
Has the child ever suffered any injuries to the teeth/head?	☐	☐			
Has the child had any problem with dental treatment?	☐	☐	Does the child suck his thumb/finger/pacifier?	☐	☐
Has the child had problems with loss of baby teeth?	☐	☐	Has the child received orthodontic treatment?	☐	☐
Does the child take fluoride supplements?	☐	☐	Is a fluoride toothpaste used?	☐	☐

What type of water is used at home? ☐ Town supply ☐ Well water ☐ Bottled water

Toothbrushing: How many times a day? ☐ Three or more ☐ Twice ☐ Once ☐ None

I certify that I have read and understand the above information. I also understand that incorrect or omitted health information above may pose serious consequences to my child's (my) health. I hereby give consent for the Delaware Division of Public Health to provide dental treatment necessary for my child (me). Authorization is hereby granted to proceed with examination, take appropriate x-rays, clean teeth, apply fluoride, provide oral hygiene instruction, administer local anesthetic (with needle), and any treatment deemed necessary including restorations (fillings) and extractions (tooth removal). I understand and will follow rules of the clinic including: providing current proof of Medicaid eligibility for each appointment, respecting that only patients are allowed in the treatment areas unless requested by the dentist, and that failure to show up for two scheduled appointments without prior cancellation will result in suspension of routine services for a period of six months.

Signature / Relationship to patient: _____ Date: _____

Providers' Signatures & Dates: _____