west chester
PEDIATRIC DENTISTRY

Bracken Webb, DDS
(513) 777-2313 · Fax (513) 779-5942
9215 Cincinnati-Columbus Rd (Route 42), West Chester, OH 45069
info@brackenwebb.com · WestChesterPediatricDentist.com

**Dental & Medical History Form - Please complete one form for each child**

## Patient Information

Last Name _____ First Name _____ MI ____ Preferred Name _____

☐ Male ☐ Female Birth Date _____ Is your child adopted? Yes No

Father/Guardian name _____ Mother/Guardian name _____

Hobbies/Interests _____

Child's Physician _____ Phone Number _____

## Dental History

What is the reason for seeing the dentist? _____

Is this your child's first dental visit? Yes No If no, date of last visit _____

Has child had dental x-rays? Yes No Location _____

Any history of pacifier, thumb sucking or finger sucking? Yes No

Any history of injuries to the mouth or teeth? Yes No

Do any family members have a history of missing teeth? Yes No

Has your child experienced any unfavorable reactions to previous medical or dental care? Yes No

Please circle if your child is having problems with any of the following:

·Cavities ·Toothache ·Grinding Teeth ·Trauma ·Gum Infections ·Sensitive Teeth ·Tooth Color

Is there anything else related to your child's teeth or mouth about which you are concerned? _____

_____

## Medical History

Does your child have or have they had any of the following: (circle those that apply)

| | | | |
|---|---|---|---|
| ADD/ADHD | Diabetes | Heart Condition | Rheumatic Fever |
| Anxiety | Depression | Hepatitis A, B, or C | Sensory Issues |
| Asthma | Developmental Delays | HIV/AIDS | Sickle Cell Disease |
| Autism Spectrum Disorder | Cancer/Tumor | Neurological Disorder | Speech Problem |
| Bleeding Disorder | Hearing Impairment | Other: _____ | |

Has your child ever been hospitalized? Yes No If yes, for what reason? _____

Has your child ever had surgery? Yes No If yes, for what reason? _____

Does your child have any allergies? Yes No If yes, what are they? _____

_____

Does your child take any medications? Yes No If yes, please list: _____

_____

Is there anything else about your child that you think we should know in order to provide the best dental care possible? _____