Kids Choice PEDIATRIC DENTISTRY
INNOVATIVE DENTAL CARE FOR THE YOUNG ONES

Pediatric Medical Health History

Child's Full Name: _____ **Nickname:** _____

Date of Birth:_____ **Gender:** ☐ **M** ☐ **F** **Race/Ethnicity:** _____

Name/Address/Phone of Primary Physician:_____

Name/Address/Phone of Medical Specialists: _____

Is your child being treated by a physician at this time?..... ☐Yes ☐No
Reason _____
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?..... ☐Yes ☐No
List name, dose, frequency & date started: _____
Has your child ever been hospitalized, had surgery, or a significant injury, or been treated in an emergency department? ☐Yes ☐No
List date & describe: _____
Has your child ever had a reaction to or problem with an anesthetic?..... ☐Yes ☐No
Describe:_____
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication?..... ☐Yes ☐No
List: _____
Is your child allergic to latex or anything else such as metals, acrylic, or dye?..... ☐Yes ☐No
List: _____
Is your child allergic to any food?..... ☐Yes ☐No
List: _____
Is your child up to date on immunizations against childhood diseases?..... ☐Yes ☐No

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after line if none of these conditions applies to your child.

Complications before or during birth?..... ☐Yes ☐No
Prematurity or birth defects, conditions?..... ☐Yes ☐No
Problems with Physical growth or development?. ☐Yes ☐No
Sinusitis, chronic adenoid/tonsil infections?..... ☐Yes ☐No
Sleep apnea/snoring or mouth breathing?..... ☐Yes ☐No
Excessive gagging?..... ☐Yes ☐No
Congenital heart defect/disease or heart murmur?☐Yes ☐No
Rheumatic fever or Rheumatic heart disease?..... ☐Yes ☐No
Irregular heartbeat or high blood pressure?..... ☐Yes ☐No
Asthma or breathing problems?..... ☐Yes ☐No
Reactive airway disease or wheezing?..... ☐Yes ☐No
Cystic Fibrosis?..... ☐Yes ☐No
Jaundice, hepatitis, or liver problems?..... ☐Yes ☐No
Gastroesophageal/acid reflux disease (GERD)?... ☐Yes ☐No
Stomach ulcer, or intestinal problems?..... ☐Yes ☐No
Lactose intolerance or dietary restrictions?..... ☐Yes ☐No
Prolonged diarrhea or unintentional weight loss?.. ☐Yes ☐No
Concerns with weight or eating disorder?..... ☐Yes ☐No
Bladder or kidney problems?..... ☐Yes ☐No

Arthritis/scoliosis/muscle, bone, joint problems?... ☐Yes ☐No
Rash/hives, eczema, or skin problems?..... ☐Yes ☐No
Impaired vision, hearing, or speech?..... ☐Yes ☐No
Developmental disorders or intellectual delays?... ☐Yes ☐No
Cerebral Palsy/Brain injury/epilepsy/seizures?..... ☐Yes ☐No
Autistic/Autism Spectrum Disorder?..... ☐Yes ☐No
Hyperactivity disorder (ADD/ADHD)…….. ☐Yes ☐No
Behavioral or psychiatric problems/treatment?..... ☐Yes ☐No
Communication problems/treatment?..... ☐Yes ☐No
Recurrent or frequent headaches/migraines?..... ☐Yes ☐No
Fainting or dizziness?..... ☐Yes ☐No
Abuse (physical/psychological/emotional/sexual) ☐Yes ☐No
Diabetes, hyperglycemia, or hypoglycemia?..... ☐Yes ☐No
Thyroid or pituitary problems?..... ☐Yes ☐No
Sickle cell disease, anemia, or blood disorder?.... ☐Yes ☐No
Hemophilia, excessive bleeding or disorders?..... ☐Yes ☐No
Transfusions or receiving blood products?..... ☐Yes ☐No
Hepatitis A, B, or C?..... ☐Yes ☐No
For females, Pregnant or possibly pregnant?... ☐Yes ☐No

Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)?..... ☐Yes ☐No
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant?..... ☐Yes ☐No
Mononucleosis, tuberculosis (TB), Scarlet fever, cytomegalovirus (CMV)?..... ☐Yes ☐No
Methicillin resistant staphylococcus aureus (MRSA)?..... ☐Yes ☐No
Sexually transmitted disease (STD), or human immunodeficiency virus(HIV)/AIDS?..... ☐Yes ☐No

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What is your primary concern about your child's oral health? _____
How would you describe your child's oral health? Choose an item.
Is there a family history of cavities? ☐Yes ☐No If yes, select from the following: ☐Mother ☐Father ☐Sibling
Does your child have any history of the following? For each YES response, please describe:

Mouth Sores or Fever Blisters? ☐Yes ☐No Describe:_____
Bad Breath? ☐Yes ☐No Describe:_____
Bleeding Gums? ☐Yes ☐No Describe:_____
Cavities/decayed teeth? ☐Yes ☐No Describe:_____
Toothache? ☐Yes ☐No Describe:_____
Clinching/grinding his/her teeth? ☐Yes ☐No Describe:_____
Jaw Joint Problems (popping)? ☐Yes ☐No Describe:_____
Excessive gagging? ☐Yes ☐No Describe:_____
Sucking habit after 1 year old? ☐Yes ☐No If yes: ☐Finger/Thumb ☐Pacifier ☐Other:_____ How long?_____

How often does your child brush his/her teeth? ☐Never ☐1-2 times a day ☐More than 3 times a day
Does someone help them brush? ☐Yes ☐No
How often does your child floss his/her teeth? ☐Never ☐1-2 times a day ☐More than 3 times a day
Does someone help them floss? ☐Yes ☐No
Please check all sources of fluoride your child receives:
☐Drinking water ☐Toothpaste ☐Over-the-counter rinses ☐Prescription rinse/gel/tablets
☐Fluoride treatment in dental office ☐Fluoride in pediatrician's office ☐Other:_____
Does your child regularly eat 3 meals a day? ☐Yes ☐No
Is your child on a special or restricted diet? ☐Yes ☐No If yes, describe:_____
Is your child a picky eater? ☐Yes ☐No If yes, describe:_____
How often does your child eat/drink sweets (candy, soda, juice, snacks)? ☐Rarely ☐1-2 times a day ☐3+times a day
Does your child participate in sports or similar activities? ☐Yes ☐No If yes, describe:_____
Does your child wear a mouthguard during these activities? ☐Yes ☐No ☐Does not apply
Has your child been examined or treated by another dentist? ☐Yes ☐No Date of last visit:_____
Were x-rays taken of the teeth or jaws? ☐Yes ☐No Date of most recent x-rays:_____
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐Yes ☐No If yes, describe:_____
Has your child ever had a difficult dental appointment? ☐Yes ☐No If yes, describe:_____
How do you expect your child will respond to dental treatment? ☐Very Well ☐Fairly Well ☐Somewhat poorly ☐Very Poorly
Is there anything else we should know before treating your child? ☐Yes ☐No
Please describe:_____

_____ _____ _____
Print Name of parent/guardian **Relationship to child** **Date**

_____ _____
Signature of parent/guardian **Signature of Staff Reviewing history**

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COVID-19 SCREENING FORM

Patient Name: _____ Temperature: _____

	Pre-Appointment Date:	In Office Date:
Do you/they have a fever or have you/they felt hot or feverish recently (14-21 days)?	☐**Yes** ☐**No**	☐**Yes** ☐**No**
Are you/they having shortness of breath or other difficulties breathing or a cough?	☐**Yes** ☐**No**	☐**Yes** ☐**No**
Have you/they experienced a recent loss of taste or smell?	☐**Yes** ☐**No**	☐**Yes** ☐**No**
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐**Yes** ☐**No**	☐**Yes** ☐**No**
Are you/they in contact with any confirmed COVID-19 positive patients ?	☐**Yes** ☐**No**	☐**Yes** ☐**No**
Is your/their age over 60?	☐**Yes** ☐**No**	☐**Yes** ☐**No**
Do you/they have a heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐**Yes** ☐**No**	☐**Yes** ☐**No**
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐**Yes** ☐**No**	☐**Yes** ☐**No**

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. I understand that it is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures may create water spray. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus. Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.

_____ _____

Print name of Parent/Legal Guardian **Parent/Legal Guardian Signature**

_____

Date

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Informed Consent

I understand that by signing below and initializing any of the following items, I am requesting and authorizing the procedure(s) to be performed and I have read and understood the possible risks and complications of the procedure(s).

1) X-Rays & Examination
I understand that my child will be receiving a dental examination from a state licensed dental practitioner. I understand that X-rays are taken of my child's teeth. My child will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant radiation exposure poses a serious threat to the life and health of my unborn child. Pregnant women are required to have a medical release from their Medical Doctor prior to X-rays and Dental treatment.

Initial _____

2) Changes in Treatment Plan
I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand there may be unforeseen changes that can occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/or all changes and additions as necessary.

Initial _____

3) Drugs and Medication
I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness or a rash, swelling of tissue, pain itching, vomiting, and/or anaphylactic shock (severe allergic reaction requiring hospitalization). I have informed the dentist of any allergies that my child has and complete medical history has been given.

Initial _____

4) Treatment
I understand that my insurance may provide only the minimum standards of care. I elect to follow Dr. Ezeanolue's recommendation of optimal treatment as detailed in the treatment plan. I understand that the information presented to me on the treatment plan is an estimate, and there may be some adjustments in the fees based on what the insurance pays.

Initial _____

5) Parent/Legal Guardian
I understand that no parent/legal guardian is allowed in the treatment room if my child is undergoing dental treatment, unless specifically requested by the dentist. We request that you do not leave the office for any reason as a precaution in the event of an emergency. No photography or videography is allowed at any time during procedures. We will inform you of any changes in treatment.

Initial _____

ACKNOWLEDGEMENT & SIGNATURE
I acknowledge no guarantee or assurance has been made by anyone regarding dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to proposed treatment.

_____ _____
Parent/Legal Guardian Name Date

_____
Parent/Legal Guardian Signature