Pediatric Dentistry & Orthodontics of Chattanooga

PDOC

Today's Date _____

Patient Yearly Update

Patient's Name_____ Date of Birth _____

Person with Patient Today _____ Relationship to Child _____

Phone # _____ Cell # _____

Email Address _____

Any Change in Address ❑ Y ❑ N If Yes,_____

Any Change in Insurance ❑ Y ❑ N If Yes,_____

Do You Have Any Concerns for the Doctor Today? _____

Child's Physician: _____

Phone # _____

Date of last visit to physician: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's current health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

Are your child's immunizations up to date? ❑ Yes ❑ No

Does your child have any drug allergies? ❑ Yes ❑ No

If yes, please list _____

_____

Is your child allergic to latex? (Balloons, Bandaids, Bananas)

❑ Yes ❑ No

Has the child ever had any unhappy dental visits? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking Fluoridated supplements? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Please list any previous hospitalizations/surgeries/serious illnesses:

_____

_____

_____

PLEASE MARK IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

	YES	NO		YES	NO
Abnormal Bleeding/Hemophilia	❑	❑	Hearing Impairment	❑	❑
Allergies	❑	❑	Heart Disease	❑	❑
Anemia	❑	❑	Heart Murmur	❑	❑
Anaphylaxis	❑	❑	Heart Surgery	❑	❑
Any Hospital Stays/Operations	❑	❑	Hepatitis	❑	❑
Artificial Heart Valve/Joint	❑	❑	Herpes/Cold Sores	❑	❑
Arthritis	❑	❑	High Blood Pressure	❑	❑
Asthma	❑	❑	HIV/AIDS	❑	❑
Autism	❑	❑	Intellectual Disability	❑	❑
Blood Transfusion	❑	❑	Kidney/Liver Problems	❑	❑
Cancer	❑	❑	Leukemia	❑	❑
Cerebral Palsy	❑	❑	Measles	❑	❑
Chemotherapy/Radiation	❑	❑	Pacemaker	❑	❑
Chicken Pox	❑	❑	Pneumonia	❑	❑
Cleft lip/Palate	❑	❑	Pregnancy	❑	❑
Convulsions/Epilepsy/Seizures	❑	❑	Premature Birth	❑	❑
Cystic Fibrosis	❑	❑	Renal Dialysis	❑	❑
Diabetes	❑	❑	Rhematic/Scarlet Fever	❑	❑
Diphtheria	❑	❑	Sickle Cell Disease	❑	❑
Down Syndrome	❑	❑	Speech Difficulties	❑	❑
Emotion, Mental, Nervous Disorder	❑	❑	Thyroid Disease	❑	❑
Frequent Nose Bleeds	❑	❑	Tuberculosis (TB)	❑	❑
Handicaps/Disabilities	❑	❑	Vision Problems	❑	❑
			Any Syndromes	❑	❑

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE GIVE A BRIEF EXPLANATION

_____

_____

x_____

SIGNATURE OF PARENT OR LEGAL GUARDIAN