

Give Kids A Smile Day

PATIENT INFORMATION

First _____ MI _____ Last _____

Date of Birth ____ / ____ / ____ Sex _____

Address _____
Street City ZIP

Phone _(_____) _____ - _____ Emergency Contact _____

PATIENT MEDICAL HISTORY

Asthma	Yes	No	Pneumonia	Yes	No
Heart Murmur	Yes	No	Headache/Migraine	Yes	No
Diabetes	Yes	No	Chicken Pox	Yes	No
Mononucleosis	Yes	No	Rheumatic Fever	Yes	No
Congenital Heart Disease	Yes	No	High Blood Pressure	Yes	No
Rheumatic Heart Disease	Yes	No	Low Blood Pressure	Yes	No
Bleeding Problems	Yes	No	Fainting Seizures	Yes	No
Kidney Disease	Yes	No	Epilepsy/Convulsions	Yes	No
Thyroid Problems	Yes	No	Leukemia	Yes	No
Anemia	Yes	No	Frequently Tired	Yes	No
Cancer	Yes	No	AIDS or HIV	Yes	No
Hepatitis/Jaundice	Yes	No	Arthritis	Yes	No
Stomach Troubles/Ulcers	Yes	No	Sexually Transmitted Disease	Yes	No
Hay Fever/Allergies	Yes	No	Chest Pains	Yes	No
Liver Disease	Yes	No	Tuberculosis	Yes	No
Mitral Valve Prolapse	Yes	No	Recent Weight Loss	Yes	No
Respiratory Problems	Yes	No	Disabilities List:	Yes	No

Physician _____ Office Phone _____ Date of last exam _____

Please list all ALLERGIES/SENSITIVITIES/DRUG REACTIONS and Reaction Type: _____

Is your child taking any medications now? If yes, please list _____

Is your child under medical treatment right now? If yes, please explain _____

Does your child use tobacco? _____ Does your child use controlled substances? _____

Does your child wear contact lenses? _____

Has your child had any other serious illness or operation?_____ If yes, please explain: _____

Is there anything else we should know about the health of your child? Please List: _____

PATIENT DENTAL HISTORY

Name of previous dentist and location _____

Date of last exam _____

Does your child's gums bleed while brushing or flossing?	Yes	No
Are your child's teeth sensitive to hot or cold liquids or food?	Yes	No
Are your child's teeth sensitive to sweet or sour liquids or food?	Yes	No
Does your child feel pain to any of his/her teeth?	Yes	No
Does your child have any sores or lumps in or near the mouth?	Yes	No
Has your child had any head, neck or jaw injuries?	Yes	No
Has your child experienced any of the following problems in the jaw:		
Clicking?	Yes	No
Pain (joint, ear or side of face)?	Yes	No
Difficulty in opening or closing?	Yes	No
Difficulty in chewing?	Yes	No
Does your child have frequent headaches?	Yes	No
Does your child clench or grind his/her teeth?	Yes	No
Does your child bite his/her lips or cheeks frequently?	Yes	No
Have you ever received oral hygiene instructions regarding the care of your child's teeth and gums?	Yes	No
Does your child like his/her smile?	Yes	No

I give consent for my child to participate in Give Kids A Smile Day program conducted by the North Central District Dental Society, North Iowa Community Action Organization and United Way of North Central Iowa. In addition, I agree to share my child's dental information with these organizations in order for my child to receive the necessary follow-up dental care.

Name of Parent/Guardian (Printed) _____

Signature _____ Date _____