Michael J. Hanna, DMD, Pediatric Dentistry, PC

New Patient Medical History

Patient Name_____Date-of-Birth_____

First Middle Last

Date of last medical exam (mm/yy)_____Results_____

Date of last dental exam (mm/yy) _____ Results_____

	Yes	No	Remarks
Are immunizations current?			
Has the patient had chicken pox, mumps or measles?			
Has the patient had whooping cough?			
Has the patient had cold sores or mouth ulcers?			
Does the patient have artificial joints or implants?			
Is the patient currently receiving medical treatment? If yes, please explain.			
Has the patient ever been hospitalized? (If yes, list dates and procedures.)			
Has the patient ever received local anesthesia?			
Has the patient ever had a reaction to local anesthesia?			
Parents, do you brush and floss your child's teeth?			
Is your water fluoridated? If supplemental fluoride is provided, list name and amount.			
When playing sports, does your child wear a mouthguard?			
Is the patient taking any medications? Please list medications, vitamins, and antibiotics.			
Does the patient have allergies (hives, rash or reactions) to drugs, medications, foods, etc? Please list.			.
Were radiographs taken at last dental exam?			

Please check the appropriate box if your child or **immediate** family member has had any of the following.

	Rheumatic Fever/ Heart Disease	Blood Disorder	Asthma/ Allergies	Seizures	Hepatitis Jaundice Liver Disease	Lung Problems/ Consistent Cough	Diabetes	Tumors	Kidney Problems
Child									
Family Member									

I understand the information on this form is essential to determine my child's dental treatment. If changes occur in my child's health, I am to report them to Dr. Hanna as soon as possible. I have read and understand each question and have answered all of them truthfully and to the best of my ability. I have discussed my child's health history with the doctor and give my consent for treatment.

_____ _____

Parent/Guardian Signature Witness Date

Michael J. Hanna, DMD_____