Michael J. Hanna, D.M.D., Pediatric Dentistry, P.C.
Medical Information (Please print.) **Date**_____

Patient Name_____

1. Month and year of last complete **medical** exam._____
   Results_____
   Are your child's immunizations current?_____

2. Is the patient receiving medical treatment now?_____

   _____

3. List any medications (include vitamins, antibiotics).
   _____

4. Does the patient have any allergies (hives, rash or reactions) to drugs, medications, foods, etc?_____

5. Has the patient ever been hospitalized?_____
   If yes, specify dates and procedures performed._____
   _____

6. If your child or immediate family member has had any of the following problems, please circle the appropriate letter and specify.

   a. Rheumatic fever, rheumatic heart disease
   b. Blood disorders
   c. Asthma, allergies
   d. Seizures
   e. Hepatitis, jaundice, liver disease
   f. Lung problems or persistent cough
   g. Diabetes
   h. Tumors
   i. Kidney problems
   j. Stomach or intestinal problems
   k. Other conditions you think Dr. Hanna should know about:
      _____
      _____

7. Has your child had any of the following? Please circle the appropriate letter.
   a. Chicken Pox c. Measles e. Cold Sores g. Artificial Joints/Implants
   b. Mumps d. Whooping Cough f. Mouth Ulcer

Patient Name_____

8. Date of last dental exam and results of visit_____
_____

Were radiographs taken?_____ How many?_____

9.. Has your child ever received local anesthesia?_____

10.Has your child ever had a reaction to local anesthesia?_____

11.Parents, do you brush and floss your child's teeth?_____

12.Is your water fluoridated?_____
If not, is supplemental fluoride being provided?_____
What is the name and amount of fluoride?_____

13.When playing sports, does your child wear a mouthguard?_____

14. What is your primary concern for your child's dental health?
_____

15. What reaction do you expect from your child to the dental visit?
_____

16. How will you feel if your child cries or refuses dental treatment?_____

"I understand the information on this form is essential to determine my child's dental treatment. I also understand that if any changes occur in my child's health, I am to report them to Dr. Hanna's office 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."

_____Date_____ _____ Date_____
Parent or Guardian Witness

_____
Michael J. Hanna, D.M.D.