WHITEANDHAINES
advanced dentistry
general dentistry
Steven M. White DDS, PA
Brad S. Haines DDS, PA

Patient Medical History – Minor/Child

Patient's Name_____**Date**_____

Minor/Child's Physician_____Phone_____

	Yes	No
Is Minor/Child under care of physician now?	☐	☐
Receiving any medications or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

If so, please list_____

List any Allergies_____

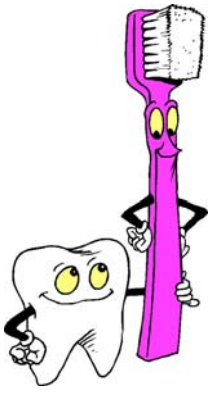
Has minor/child had any history of or difficulty with any of the following? If yes, please check.

A.I.D.S./H.I.V.	☐	Anemia	☐	Epilepsy	☐
Asthma	☐	Chicken Pox	☐	Fainting	☐
Bladder Problems	☐	Convulsions	☐	Hearing Problems	☐
Cancer	☐	Diabetes	☐	Heart Problems	☐
Cerebral Palsy	☐	Drug Abuse	☐	Hepatitis	☐
Kidney Disease	☐	Liver Disease	☐	Measles	☐
Mononucleosis	☐	Mumps	☐	Rheumatic Fever	☐
Sinus Problems	☐	Thyroid	☐	Tuberculosis	☐
Other	☐				

Patient Dental History – Minor/Child

Date of last visit to a dentist_____For what service?_____

	Yes	No
Has child complained about dental problems?	☐	☐
Is fluoride taken in any form?	☐	☐
Does child brush teeth daily & floss?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, etc?	☐	☐



X_____ _____

Signature of patient or parent/guardian if minor ***Date***