Greenburgh Kids Dental
Pediatric Dentistry

MEDICAL HISTORY UPDATE

PLEASE PRINT

Date _____

Patient's Name _____ Nickname_____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

Age _____ Birth date_____ Female/Male _____

MEDICAL HISTORY

YES	NO		YES	NO		
☐	☐	Heart Murmur	☐	☐	Hepatitis/Liver Disease	
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease	
☐	☐	Asthma	☐	☐	Diabetes	
☐	☐	Heart Disease	☐	☐	Epilepsy	
☐	☐	Thyroid Disease	☐	☐	Nervous Disorder	
☐	☐	High Blood Pressure	☐	☐	Tumor, Cancer	
☐	☐	Lung Disease	☐	☐	Cardiac Pacemaker	
☐	☐	Metallic Implant, Shunts, Pins or Rods	☐	☐	Measles	
☐	☐	Sore Throats	☐	☐	Tonsillitis	
☐	☐	Tuberculosis	☐	☐	Ear aches	
☐	☐	Chicken Pox	☐	☐	Glaucoma	
☐	☐	Prolonged Bleeding When Cut	☐	☐	Mumps	
☐	☐	Blood Transfusion	☐	☐	Bad Breath	
☐	☐	Injury to Front Teeth	☐	☐	Stained Teeth	
☐	☐	Bleeding Gums	☐	☐	Cold Sore, Fever Blister	
☐	☐	**DRUG/FOOD ALLERGY**	☐	☐	Women: Are you Pregnant Now?	
		If yes, to what medications/foods?	☐	☐	AIDS	
		_____	☐	☐	Chemical Dependency	
☐	☐	ADD /ADHD	☐	☐	Developmentally Delayed	
		Attention Deficit Disorder/			Age level patient is at _____	
		Attention Deficit Hyperactivity Disorder				

COMMENTS
(for Office Use Only)

Is the patient taking any medications? **Yes** ❑ **No** ❑

If so, please list the medications: _____

Has the patient recently been under the care of a physician? Y ❑ N ❑ Reason: _____

Name of Medical Doctor for above reason: _____

RESPONSIBLE PARTY INFORMATION

Resident Parent _____ _____

               Last   First   Middle Initial   Marital Status

Address _____

        Street   City   State   Zip

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address:_____

Previous Address(if less than 3 yrs.) _____

        Street   City   State   Zip

Social Security # _____ Birth date _____ Relationship to patient _____

Employer_____ Occupation_____ Yrs. Employed_____

Other Parent _____

           Last   First   Middle Initial

Address (if not the same) _____

        Street   City   State   Zip

Social Security # _____ Birth date _____ Relationship to patient _____

Home Phone _____ Work Phone_____

Employer_____ Occupation_____ Yrs. Employed_____

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____ Insured's Soc. Sec. #_____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Insurance Phone #_____

Do You have dual coverage? ☐ Yes ☐ No

Secondary Insured's Name _____ Insured's Soc. Sec. #_____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Insurance Phone #_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Phone _____

_____
Signed (Parent or Guardian)