Chemung
FAMILY DENTAL
RICHARD B. DUNN, DDS
1007 BROADWAY
ELMIRA, NY 14904
(607) 734-2045
WWW.CHEMUNGFAMILYDENTAL.COM

Parent or guardian must accompany all minors under age 18 during their dental visits.

CHILDREN'S MEDICAL HEALTH HISTORY

Patient's Name: _____ Birth Date: _____ Today's Date: _____
Address: _____ City: _____ State ____ Zip _____
Parent's Name _____ Home Phone: _____
Email: _____ Cell Phone: _____
Physician's Name: _____ Referred To Us By: _____
School: _____
Dental Insurance Co. Name: _____
Most Convenient Day & Time For Your Dental Appointments: _____
Purpose of This First Dental Visit: _____

Person Financially Responsible For This Account: _____
Address: _____ *Home Phone:* _____
Employment Name & Address: _____ *Social Security No.:* _____
Emergency Contact _____ *Phone* _____

Is it okay to contact your Emergency Contact with your present medical condition? _____ *Yes* _____*No*

Please check the best answer, and complete the blank lines where appropriate:

- Is this the patient's 1st visit to any dentist? . . . . ____ Yes ____ No
- Is he (she) under medical treatment now? . . . . ____ Yes ____ No
  In the past year? If YES, for what? _____
- Does he (she) brush his teeth less than twice a day? . . . . ____ Yes ____ No
- Does he (she) have any allergies? . . . . ____ Yes ____ No
- Is he (she) allergic to any particular medications? . . . . ____ Yes ____ No
- Has he (she) ever had a reaction to Novocaine/local anesthesia? . . . . ____ Yes ____ No
- Does he (she) have frequent nose bleeds? . . . . ____ Yes ____ No
- Is he (she) taking any medication now? . . . . ____ Yes ____ No
- Has he (she) had a recurring sore throat? . . . . ____ Yes ____ No
- Is he (she) considered a nervous person? . . . . ____ Yes ____ No
- Does he (she) eat between meals? . . . . ____ Yes ____ No
- Has he (she) ever had a sever toothache? . . . . ____ Yes ____ No
- Has he (she) had any injuries to his (her) teeth? . . . . ____ Yes ____ No
- Has he (she) gained or lost much weight lately? . . . . ____ Yes ____ No
- Check if your child ever had: ___rheumatic fever; ___diabetes; ___epilepsy; ___thrush;
  ___anemia; ___kidney trouble; ___liver trouble; ___heart trouble; ___hepatitis; ___asthma;
  ___tuberculosis; ___circulatory, bleeding problems; ___immune system diseases?
  other illnesses . . . . ____ Yes ____ No
  If YES, what: _____
- Does he (she) have any mouth habits? . . . . ____ Yes ____ No
- How long since he (she) has been to a dentist? _____
- What was done at this visit? . . . . ____ Yes ____ No
- Did he (she) make regular visits before then? . . . . ____ Yes ____ No
- Did he (she) have X-rays taken regularly? . . . . ____ Yes ____ No
- How often does he (she) brush his (her) teeth? _____ When: _____

Does he or she have a hard time sleeping or breathing at night? . . . . . ____ Yes ____ No

Does he or she have their tonsils? . . . . . ____ Yes ____ No

Does he or she snore? . . . . . ____ Yes ____ No