Dr. Mark Olivito & Associates

COMBINED (Health & Dental) FORM – CHILD

Date: _____ Name: _____ _____ DOB: _____
DD MMM YYYY FIRST LAST DD MMM YYYY

Address:_____ Phone:_____ Gender: F☐ M ☐

Email Address:_____

Guardian 1 Name _____ Relationship _____
Guardian 2 Name _____ Relationship_____
Guardian 3 Name _____ Relationship _____

HEALTH HISTORY

Physician Name :_____ Location: _____
Is the child under the regular care of a physician and/or a medical specialist? Y☐ N ☐ *If yes, please explain.*
Specialist Name :_____ Location: _____
_____
_____

1. Are the child's immunizations up to date? Y☐ N ☐
2. Has the child ever been hospitalized overnight? Y☐ N ☐ *If yes, please explain.*
   _____
3. What is the child's pharmacy of record? _____
4. Has the child recently, or is the child presently taking any prescription or non-prescription medications, vitamins or supplements? Y☐ N ☐ *If yes, please list medications OR attach a list.*
   _____
   _____
5. Has the child ever had any adverse or unusual reaction to any medications/injections or been advised against taking any specific type of medications (Penicillin, Sulpha, Aspirin, Codeine, Local anesthetic/freezing, Nitrous Oxide or any other medications)? Y☐ N ☐ *If yes, please explain.*
   _____
   _____
6. Does the child have asthma? Y☐ N ☐
7. Does the child have any allergies or an allergic condition (Food, medication, Hay Fever, Seasonal Allergies etc)? Y☐ N ☐
   If yes, please explain.
   _____
8. Has the child ever fainted during dental or medical treatment? Y☐ N ☐
   _____
9. a) Has the child ever had dental treatment completed with (Check All That Apply): Y☐ N ☐
   Nitrous Oxide (Laughing Gas) Y☐ N ☐ Conscious Sedation Y☐ N ☐ General Anesthetic Y☐ N ☐
   b) *If yes*, When _____ Where _____ Do you feel it was successful? Y☐ N ☐
10. Does the child wear eye glasses? Y☐ N ☐ Contact lenses? Y☐ N ☐
11. Does the child have any hearing difficulties? _____ Y☐ N ☐
12. Has the child ever had any form of cancer? Y☐ N ☐
    *If yes, did the child receive radiation or chemotherapy treatments?*_____ When?_____

13. Please indicate which of the following the child presently has or has ever had:

ADHD Y☐ N ☐
AIDS/HIV Y☐ N ☐
Anemia Y☐ N ☐
Anxiety/Depression Y☐ N ☐
Arthritis Y☐ N ☐
Asthma Y☐ N ☐
Autism Y☐ N ☐
Bleed Excessively Y☐ N ☐
Bruise easily Y☐ N ☐
Celiac Disease Y☐ N ☐
Cerebral Palsy Y☐ N ☐
Chicken Pox Y☐ N ☐
Circulation Problems Y☐ N ☐
Cold Sores/Herpes Y☐ N ☐
Cortisone/Steroid Therapy Y☐ N ☐
Crohn's/Colitis/IBS Y☐ N ☐

Diabetes Y☐ N ☐
Eating Disorder Y☐ N ☐
Epilepsy or Seizures Y☐ N ☐
Fibromyalgia Y☐ N ☐
Heart Issue(s) Y☐ N ☐
☐ Heart Disease
☐ Heart Murmur
☐ Heart Rhythm Disorder
☐ Heart Surgery_____
☐ Mitral Valve Prolapse
☐ Other_____
Hepatitis ☐A ☐B ☐C Y☐ N ☐
☐High/☐Low Blood Pressure Y☐ N ☐
Kidney Disease Y☐ N ☐
Liver Disease Y☐ N ☐
Lung Disease Y☐ N ☐

Lupus Y☐ N ☐
Malignant Hyperthermia Y☐ N ☐
Migraines Y☐ N ☐
MS (Multiple Sclerosis) Y☐ N ☐
Organ Transplant Y☐ N ☐
Scarlet/Rheumatic Fever Y☐ N ☐
Sickle Cell Disease Y☐ N ☐
Speech Disorder Y☐ N ☐
Stroke/TIA _____ Y☐ N ☐
Thyroid Disease Y☐ N ☐
Tonsillitis Y☐ N ☐
Tuberculosis Y☐ N ☐
Ulcers (H Pylori) Y☐ N ☐
Venereal Disease Y☐ N ☐
Vertigo/Dizzy Spells Y☐ N ☐

Other:
_____

14. Are there any other conditions/diseases not listed above or is there anything else regarding the child's health history that we should be made aware of? Y☐ N ☐
_____

15. Do you wish to speak privately to the Doctor about any concern or medical condition? Y☐ N ☐

DENTAL HISTORY

1. Has the child had previous dental care? Y☐ N ☐
2. Has the child had fluoride (treatments, toothpaste)? _____ Y☐ N ☐
3. Has the child ever had orthodontic treatment (braces, spacers)? _____ Y☐ N ☐
4. Has the child ever had an injury or trauma to the mouth, face or jaw? _____ Y☐ N ☐
5. Does the child have any of the following habits (Check All That Apply):
   ☐Thumb/Finger Sucking ☐Lip Biting ☐Tongue Thrusting ☐Nail Biting ☐Mouth Breathing
   ☐Teeth Grinding ☐Smoking/Vaping ☐Other _____
6. Is there a family history of (**Check All That Apply**):
   ☐Tooth Decay/Cavities ☐Gum Disease ☐Malformed Teeth ☐Extra Teeth ☐Missing Teeth
   ☐Orthodontic treatment (Braces) ☐Other_____
7. a) How often does the child brush their teeth? _____
   b) Do you assist the child with their oral hygiene? _____ Y☐ N ☐
8. Has the child ever had an unpleasant experience at the dentist?_____ Y☐ N ☐

9. a) How would you rate the child's dental anxiety (**Choose One**): ☐High ☐Moderate ☐Low
   b) How would you rate your own dental anxiety (**Choose One**): ☐High ☐Moderate ☐Low

10. How do you think the child has reacted to medical procedures in the past (**Choose One**):
    ☐Very Well ☐Well ☐Poorly ☐Very Poorly

11. How well do expect the child to accept dental treatment (**Choose One**)?
    ☐Very Well ☐Well ☐Poorly ☐Very Poorly

12. Do you consider the child to be **(Choose One)**:
    ☐Advanced in Learning ☐Progressing Normally ☐Learns with Additional Assistance

13. What is your child most interested in (Books, Sports, Games, Hobbies, etc)?

_____

_____

In the event of an emergency with the child, please contact:

Name: _____ Relationship:_____ Number:_____

General Release

I, the undersigned, certify that I have provided an accurate and complete personal, health and dental history for the child and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding the child's health and dental history**.** Should there be any change in the child's health status or any other information I have provided, I will advise the dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to the child's medical doctor or other health care provider may be necessary. I have been advised of the privacy policy of the office and that personal information will be collected, used and disclosed within the guidance of the policy. I understand that responsibility for payment of the dental services is mine, and I assume responsibility for fees associated with these services.

Guardian Signature: _____

Name of Guardian: _____