Kansas City Pediatric Dentistry
3801 Southwest Trafficway • Kansas City, MO 64111 • (816) 622-2000

THE FOLLOWING INFORMATION AND HISTROY ARE NECESSARY FOR TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient Medical History

Patient's Name_____
Patient's Physician_____Phone#_____
Physician's Address _____City_____State_____Zip_____

Health History

	Yes	No	
Is your child in good health?	☐	☐	
Does your child have regular medical exams?	☐	☐	When was the last exam?_____
Is your child up-to-date with immunizations?	☐	☐	
Is your child presently undergoing medical treatment?	☐	☐	If so, for what?_____
Has your child been hospitalized since birth or had any operations?	☐	☐	Date/Reason_____
Does your child have any infectious diseases?	☐	☐	If yes, list_____
Is your child presently taking medications?	☐	☐	If so, what?_____
Have there been any unfavorable reactions to medications?	☐	☐	If so, what?_____
Is your child allergic to latex?	☐	☐	
Does your child have any other allergies?	☐	☐	If so, what?_____

Health History

Check conditions that your child has currently or been affected by in the past.

☐ADD/ADHD	☐Blood Transfusions	☐Chemotherapy	☐Pregnancy	☐Arthritis
☐Asthma	☐Kidney Problems	☐Transplant Surgery	☐Stomach Problems	☐Cancer
☐Emotional Disorder	☐Special Ed Classes	☐HIV/AIDS	☐Autoimmune Disorder	☐Bruise Easily
☐Epilepsy/Seizure	☐Speech Disorder	☐Hepatitis A-B-C	☐Fetal Alcohol Syndrome	☐Leukemia
☐Hearing Condition	☐Speech Therapy	☐Vision Disorder	☐Eating Disorders	☐NEED antibiotics
☐Frequent headaches	☐Tuberculosis	☐Sleep Apnea/Snoring	☐Stomach Problems	for dental procedures
☐Autism	☐Latex Allergy	☐Neurological Disorder	☐Thyroid Disease	☐ Other
☐Bleeding Disorder	☐Liver Problems	☐Nervous Disorder	☐Herpes/Cold Sores	
☐Brain Injury	☐Lung Problems	☐Chronic Cough	☐Heart Murmur	
☐Chemical Dependency	☐Occupational Therapy	☐Recurrent Mouth Sores	☐Mononucleosis	Health History Reviewed
☐Cerebral Palsy	☐Cleft lip or palate	☐Celiac Disease	☐Fainting Spells	(initials date)
☐Down Syndrome	☐Skin Disorder	☐Radiation Treatments	☐Rheumatic Fever	_____ _____
☐Developmental Delay	☐Sickle Cell Anemia	☐Cystic Fibrosis	☐High Blood Pressure	_____ _____

If you answered yes for any question above or for a condition not listed, please explain: _____
_____
What is your water source? ☐Public System ☐Private Well ☐Bottle Water ☐Filtration System; Name of System: _____
Is this your child's first dental visit? ☐Yes ☐No If not, date of last dental care _____
Prior dentist _____
Has your child ever had trouble, problems or anxiety with previous dental care? ☐Yes ☐No
Has your child ever required an antibiotic prior to dental treatment? ☐Yes ☐No
Is your child having dental problems or do you have specific concerns? _____
Purpose of this visit? _____
If there is any information that you think might be of value to us in treating your child, please feel free to comment:
_____

FINANCIAL AGREEMENT: Payment is required for services rendered at the time the treatment is performed.
Method of Payment: ☐Cash ☐Check ☐Credit Card (MasterCard, Visa, Discover)
I agree to diagnostic and cleaning procedures as found necessary by Kansas City Pediatric Dentistry for the patient named above. I accept responsibility for this account should the named responsible party fail or insurance benefit be denied or be insufficient to pay the full fee.
I also acknowledge that I have received a copy of Notice of Privacy Practices.

Date: _____ Signature:_____