Snoqualmie Ridge Family Dental

Pediatric Medical & Dental Health History

In order to serve you/your child effectively and safely, please complete the questionnaire to the best of your knowledge. This is a confidential record. The information will not be released without your permission.

Patient Name: _____ Date of birth: _____ Today's date: _____

Medical History

How would you rate the patient's general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Weight: _____

Within the last year, are there any changes in the general health? ☐ No ☐ Yes: _____

Does the patient have any known allergies? Please select all that apply. ☐ No known drug allergies

☐ Penicillin, amoxicillin, and related antibiotics
☐ Antibiotics containing sulfanomides (sulfa drugs)
☐ Aspirin, ibuprofen, and other non-steroidal anti-inflammatory drugs (NSAIDs)
☐ Codeine
☐ Other: _____
☐ Local anesthetics
☐ Latex (rubber)
☐ Seasonal/hay fever
☐ Anticonvulsants
☐ Metal(s) _____

Does the patient currently taking prescription medications? ☐ No ☐ Yes: _____

Does the patient currently taking non-prescription or over-the-counter (OTC) medications? ☐ No ☐ Yes: _____

Does the patient currently taking vitamins, supplements, or herbal medicine? ☐ No ☐ Yes: _____

Does the patient have any of the following conditions? (check all that applies)

☐ None of the following apply
☐ Blood/Bleeding Conditions
☐ Lung Conditions
☐ Heart Conditions
☐ Stomach/Gastro-intestinal Conditions
☐ Endocrin/Hormone Conditions
☐ Autoimmune Conditions
☐ Others: _____

Dental History

Name of previous dentist: _____ Approximate date of last dental exam: _____

Brushing Routine: ☐ 1 time per day ☐ 2 times per day
☐ Patient brushes on his/her own ☐ Parents check afterwards ☐ Parents help

Flossing Routine: ☐ Not currently flossing ☐ 1 time per day

Type of toothpaste used: ☐ With Fluoride ☐ Without Fluoride

Do any of the following apply? (check all that applies)

☐ Pacifier use
☐ Bottle to bed. Types of liquid added _____
☐ Difficulty latching during breast feeding
☐ Thumb/Finger sucking
☐ Snoring
☐ Night time teeth grinding
☐ Biting on foreign objects (non-food) _____
☐ Tongue Thrusting

Does the patient have any teeth or jaw pain currently? ☐ No ☐ Yes

Does the patient have any questions or concerns about his/her teeth? ☐ No ☐ Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Signature_____ **Date**_____

Parent/guardian signature if under 18

Last Minute Cancellation, Late Arrival, and No Show Policy

We want to thank you for choosing Snoqualmie Ridge Family Dental (SRFD) for your dental care needs. We strive to provide you with the best possible care in a timely matter. Your scheduled appointment will ensure that you are given a proper amount of time needed for your visit. It is very important that you attend your scheduled appointment on time.

We understand that sometimes there may be emergencies or schedule changes and you may need to reschedule or cancel your appointment. As a courtesy to our office, as well as to those patients who are waiting to schedule with the office, please call the office to reschedule or cancel as soon as possible (with at least a 48-hour notice). This would allow us to offer your cancelled appointment to other patients.

Late arrival, last minute cancellation, or no show will result in a $100 fee to be charged to your account. Your dental insurance company does not cover this fee. Repeated late arrivals, last minute cancellations, or no shows would affect our ability to provide care for you, and our office may decide to terminate the relationship with you.

-"No show": if you are not present for your scheduled appointment
-"Last minute cancellation": cancellation with less than a 48-hour notice
-"Late arrival": being more than 10 minutes late to the scheduled appointment

I acknowledge that I have read, understand, and agree to SRFD's Last Minute Cancellation, Late Arrival, and No Show policy. I understand my responsibility to plan appointments accordingly and to notify SRFD appropriately if I cannot keep my scheduled appointments.

_____ _____

Patient Name **Patient Signature**

_____

Date