

# Welcome To Our Office

**Wachusett Pediatric Dentistry**  
Thafur Shemmeri, DMD, MScD, DScD, P.C.  
Diplomate of the American Board of Pediatric Dentistry

# HEALTH HISTORY FORM

PLEASE PRINT

## Patient Information

Name \_\_\_\_\_ Nickname: \_\_\_\_\_ Male  Female  D.O.B. \_\_\_\_\_

Home Address: \_\_\_\_\_  
Number Street City State Zip

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Do we have permission to leave messages via voicemail/text?  Yes  No

E-Mail Address \_\_\_\_\_

Adopted?  Yes  No Twin?  Yes  No

## Parental/Guardian Information

Father's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone: \_\_\_\_\_  
(if different than above)

Home Address: \_\_\_\_\_  
(if different than child's) City State Zip

Employed by: \_\_\_\_\_ Present Position: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone: \_\_\_\_\_  
(if different than above)

Home Address: \_\_\_\_\_  
(if different than child's) City State Zip

Employed By: \_\_\_\_\_ Present Position: \_\_\_\_\_

Married  Divorced  Separated  Other

## General Health Information

Child's Physician or Pediatrician: \_\_\_\_\_

Address: \_\_\_\_\_  
Number Street City State Zip

Phone: \_\_\_\_\_

Does our office have permission to contact your child's M.D. if needed?  Yes  No

Is your child in good health? \_\_\_\_\_ If not, briefly describe conditions \_\_\_\_\_

Has your child ever been hospitalized? When, where, and for what reason? \_\_\_\_\_

Does your child have any physical and/or mental special needs? \_\_\_\_\_

For what reason did you schedule this appointment? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

List your child's interests and hobbies: \_\_\_\_\_

	Yes	No (Check One)
Has the patient ever been treated orthodontically (braces or dental appliances)	_____	_____
Have tonsils or adenoids been removed?	_____	_____
Is the patient a mouth breather?	_____	_____
Have you ever been informed of extra or missing teeth?	_____	_____

## MEDICAL HISTORY

**Has your child had any of the following:**

	Yes	No		Yes	No (Check One)
Measles (Rubella)	_____	_____	German Measles (Rubella)	_____	_____
Canker Sores	_____	_____	Cold Sores (Herpes Simplex)	_____	_____
Mumps	_____	_____	Chicken Pox (Varicello)	_____	_____
Tuberculosis	_____	_____	Infectious Mononucleosis	_____	_____
Hepatitis (Serum)	_____	_____			
(Infectious)	_____	_____			

Is your child presently on any medications?     Yes     No

If yes, describe \_\_\_\_\_

List any surgeries your child has had: \_\_\_\_\_

**Has your child had a history of:**

	Yes	No		Yes	No (Check One)
Allergies	_____	_____	Bleeding Disorder	_____	_____
Food	_____	_____	If yes, describe _____		
If Yes, describe _____			Respiratory Disorder	_____	_____
Pollen	_____	_____	Asthma	_____	_____
Drug	_____	_____	Cystic Fibrosis	_____	_____
If yes, describe _____			Other	_____	_____
Other	_____	_____	Gastro Intestinal Disorder	_____	_____
Heart Disease	_____	_____	Diabetes Mellitus	_____	_____
Rheumatic	_____	_____	Diabetes Insipidus	_____	_____
Congenital	_____	_____	Liver: Jaundice	_____	_____
Murmur	_____	_____	Communicable Diseases	_____	_____
Other	_____	_____	Does your child have		
Genitourinary Disease	_____	_____	any medical problems		
Bladder	_____	_____	or is he/she being		
Kidney	_____	_____	treated or observed for		
Other	_____	_____	any illness?	_____	_____
Learning Disorder	_____	_____	Does your child have any		
Immunological Disorder	_____	_____	pins, screws, or plates		
Emotional Disorder	_____	_____	placed in their body?	_____	_____
Anxiety	_____	_____	If yes, describe _____		
Drug Reactions	_____	_____			
Seizures	_____	_____			
If Yes, describe _____					

### AUTHORIZATION TO TREAT

*List people authorized to bring child to dental appointment other than parent(s)/guardian(s).*

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Initial and Date on line when updating:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_ 10. \_\_\_\_\_