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 any medical problems or is he/she being treated or observed for any illness?		
Genitourinary Disease					
Bladder					
Kidney					
Other					
Learning Disorder					
Immunological Disorder					
Emotional Disorder					
Anxiety					
Drug Reactions					
Seizures					
If Yes, describe _____			Does your child have any pins, screws, or plates placed in their body?		
			If yes, descibe _____		

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. _____