

Pediatric Dental Specialists

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HEALTH HISTORY

Date: _____

Child's Name: _____ Nick Name: _____

Age: _____ Date of Birth: _____ Male Female

MEDICAL HISTORY

Pediatrician: _____ Phone: _____

Date of last physical: _____

Is your child in good health? Yes No

Are immunizations up to date? Yes No

Is your child taking any medications? Yes No

Please list: _____

Please circle Y or N regarding your child's history of the following:

Y N Allergies/Environmental

Y N Cancer/Tumors

Y N HIV/AIDS

Y N Allergies Foods/Dyes

Y N Cleft Lip/Palate

Y N Hyperactivity / ADD / ADHD

Y N Allergies Medications

Y N Diabetes

Y N Hospitalizations / Surgery

Y N Latex Allergy

Y N Epilepsy / Seizures

Y N Kidney Disease

Y N Anemia/ Bleeding Problems

Y N Growth/Development Problems

Y N Rheumatic Fever

Y N Asthma

Y N Hearing / Speech Problems

Y N Sickle Cell Disease

Y N Autism / PDD

Y N Heart Murmur / Heart Disease

Y N Birth defects / Disabilities

Y N Hepatitis / Liver Disease

If you answered Yes to any of the above, please explain: _____

Other medical information we should know about your child: _____

DENTAL HISTORY

Previous Dentist: _____ Date of Last Visit: _____

Reason for leaving last dentist: _____

Reason for today's visit: _____

Does your child brush daily? Yes No

How Often? _____

Floss their teeth daily? Yes No

Do you help your child brush and floss? Yes No

Has your child had any injuries to the teeth, mouth or jaws? Yes No _____

Has your child had or have any of the following habits?

Y N Thumb/Finger Sucking

Y N Nail Biting

Y N Snoring

Y N Lip Sucking/Biting

Y N Nursing Bottle Habits/Pacifier

Y N Grinding

To the best of my knowledge, the above information is complete and accurate. I understand that this information may be disclosed in treatment, for payment, and in normal healthcare operations. I understand that I am responsible for any financial obligation incurred for the services provided.

Signature _____ Relationship _____ Date _____

Reviewed by Doctor _____