TED LOIBEN, D.D.S.
MEDICAL AND DENTAL HEALTH HISTORY

DATE: __________________

Patient Name _________________________________ Date of Birth _________Weight _____

Name of Contact (other than parents) for Emergencies __________________________________

Contact's Relationship to Patient _________________ Phone # __________________________

Pediatrician's Name ____

____ ______________________
Address (or city) Phone

1. Is your child under a physician's care at this time? _____

   If Yes, why? ____

2. Is your child presently taking any medication? _____

   If Yes, name of medication ______________ Dosage _______________________

3. Has your child had an allergic reaction to any medication or an adverse drug reaction? __

   If Yes, what medication(s)? ___________________ Describe reaction: _____________

   ____

4. Has a physician ever informed you that your child requires antibiotics before dental treatment? _________

5. Has your child ever been hospitalized? __________
   If Yes, describe the circumstances (why, when, where?)

   ____

   ____

6. Please place an "X" to indicate if your child has a history of the following:

___ Anemia	___ Bleeding Problems	___ Cerebral Palsy
___ Arthritis	___ Speech Problems	___ Muscular Dystrophy
___ Asthma	___ Breathing Problems	___ Chicken Pox
___ Autism	___ Circulatory Problems	___ Physical Disabilities
___ Diabetes	___ Hearing Problems	___ Learning Disabilities
___ Epilepsy	___ Heart Problems	___ Mental Retardation
___ Hepatitis	___ Heart Murmur	___ Nutritional Problems
___ HIV Positive	___ Kidney Problems	___ Metabolism Problems
___ Malignancies	___ Liver Problems	___ Rheumatic Fever
___ Measles	___ Intestinal Problems	___ Scarlet Fever
___ Mumps	___ Nervous Problems	___ Tonsillitis
___ Seizures	___ Glandular Problems	___ Psychiatric Problems

CHECK HERE IF YOUR CHILD HAS NO HISTORY OF ANY OF THE ABOVE: ___ NONE

7. Are there any other pertinent facts in your child's history? ________________________

____

8. Reason for today's visit ____

9. Is this your child's first visit to the dentist? ______________________________________

10. Does your child have any particular fears or apprehensions? _______________________

____

11. Has your child ever had a negative dental or medical experience? Describe. __________

____

12. What could Dr. Loiben do differently than previous doctors to satisfy you? ___________

____

13. How were you referred to Dr. Loiben? ____
We like to acknowledge our patients for referring others. If you prefer not to have your name mentioned please circle. NO

***I have provided all pertinent facts regarding my child's medical and dental history*.**

Signature of Parent or Legal Guardian: ______________________________ Date: _________