

Culver Family Dentistry

Alan Litvinov, D.D.S

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PEDIATRIC DENTAL AND MEDICAL HISTORY

Patient name _____

Date of Birth ____/____/____ Parent's Name _____

MEDICAL HISTORY
 Name of child's physician _____ Date of last physical exam ____/____/____
 Physician's address _____ Physician's phone number _____

Does your child have any **CURRENT HEALTH PROBLEMS**? No Yes

Is your child under a physician's care now? (if Yes, see below)
If yes, for what? _____

What **MEDICATIONS** is your child currently taking? (if any, list below)
Medications: _____

Has your child ever had a serious illness, operation, or hospitalization?
If so, for, what? _____ When? _____

CIRCLE ANY OF THE FOLLOWING YOUR CHILD HAS HAD, OR PRESENTLY HAS:

Rheumatic Fever	Anemia	Hepatitis/Liver Disease	Hemophilia
Heart Disease	Tuberculosis	Brain Injury	Transfusions
Heart Murmur	Lung Disease	Seizures	Tumors/Growth
High Blood Pressure	Asthma	Speech Disorder	Kidney Disease
Sickle Cell	Allergies or Hives	Emotional Disorder	Other: _____
Disease/Trait	Diabetes	Bleeding Disorder	
Blood Disease			

IS YOUR CHILD ALLERGIC TO OR HAS HE/SHE REACTED ADVERSLY TO ANY OF THE FOLLOWING:

Aspirin	Nitrous Oxide	Penicillin	Codeine
Tylenol	Local Anesthetic	Erythromycin	Sedative

Other medicines or substances? _____

DENTAL HISTORY
 How long since your last dental visit? _____ Date of last FULL MOUTH X-RAYS: ____/____/____
 Date of last COMPLETE dental exam: ____/____/____
 What is your child's present dental health? (Circle one) POOR AVERAGE EXCELLENT
 No Yes

Any **INJURIES** to teeth, mouth or head?
 Are you or your child having a **PROBLEM** now?
 If Yes, explain: _____
 Any oral habits? (Circle those that apply) THUMBSUCKING NAILBITING MOUTHBREATHING
 Has your child ever taken a **BOTTLE** at nap or bedtime?
 Is this your child's **FIRST** visit to the dentist?
 Has your child had an **UNHAPPY** dental or medical visit?
 What is your child's attitude towards dentistry? (Circle one) POSITIVE NEGATIVE
 Summary of dental history:

To the best of my knowledge, the above questions have been answered accurately. I hereby consent to the initial examination, including the taking of diagnostic radiographs (x-rays), photographs and casts as deemed necessary by Dr. Alan Litvinov

_____ Date _____ Signature of parent/guardian

FOR DOCTOR'S USE ONLY

Summary of medical history/medical problems affecting dental treatment _____

 Remarks _____
 Hx obtained from _____
 Doctor's signature _____ Date ____/____/____

PATIENT REGISTRATION

Patient Name: _____ **Today's Date:** _____

Date of birth: _____ **Age:** _____ **Male/Female:** _____ **Social Security Number:** _____-____-_____

Address: _____ **City** _____ **St.** _____ **Zip** _____

Home Phone Number: (____) _____ **Work Phone Number:** (____) _____

Cell Phone Number: (____) _____

Status (Circle One): Single, Married, Divorced, Separated or Widowed

Email Address _____

Employer Name and Address: _____

Present Position _____

Whom may we thank for referring you? _____

Name of Spouse, Parent or Custodian: _____

Date of birth: _____ **Age:** _____ **Male/Female:** _____ **Social Security Number:** _____-____-_____

Email address: _____

Home Phone Number: (____) _____ **Work Phone Number:** (____) _____

Spouse's Employer Name and Address _____

Emergency Contact Person _____

Emergency Contact's Address _____

Emergency Contact's Home Phone Number: (____) _____

Emergency Contact's Work Phone Number: (____) _____

Primary Dental Insurance Co: _____

(Name) (Address)

Name of Policy Holder: _____ **Group or ID #:** _____

Secondary Dental Insurance Co: _____

(Name) (Address)

Name of Policy Holder: _____ **Group or ID #:** _____

Person Responsible for this Account: _____

I hereby authorize Dr. Alan Litvinov and his team to perform dental treatment which may include the use of local anesthesia, nitrous sedation, x-rays or diagnostic tests. I understand that, though good results are expected, the possibility and nature of complications such as swelling, infection, discoloration of the face or neck, bruising, muscle or TMJ soreness, or difficulty swallowing cannot always be accurately anticipated.

Signature of Patient, Parent or Guardian: _____ **Date:** _____