Pediatric Interval History Form
Greenpoint Pediatric Dentistry

Patient's Name (Last):______ (First):______ (Middle):______
Date of Birth:______ Gender: □ Male □ Female Height:______ Weight:______

Please provide any changes in your child's provider information.

Primary/ Referring Dentist:______ Last visit:______
Address:______ Phone Number:______
Primary Physician:______ Last Visit:______
Address:______ Phone Number:______

Please describe any changes in your child's health since the last visit or within the last 6 months.

Is your child being treated by a physician at this time?______ □ Yes □ No
If yes, reason:______
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?______ □ Yes □ No
If yes, list name, dose, frequency & date started:______
Has your child ever been hospitalized, had surgery or a significant injury or
Has your child been treated in an emergency department?______ □ Yes □ No
If yes, please list and describe:______
Has your child ever had a reaction to/ problem with an anesthetic, medication, or latex? ______ □ Yes □ No
If yes, describe:______
Is your child up to date on immunizations against childhood diseases?______ □ Yes □ No

Please describe the reason for your present visit.

What is your primary concern about your child's oral health?______
Has your child had any pain or injury to the mouth/teeth/jaws since last visiting our office?______ □ Yes □ No
Describe:______
Has your child's diet changed significantly since his/her last dental visit?______ □ Yes □ No
Describe:______
Has your child been treated by another dental professional since last visiting our office? ______ □ Yes □ No
Reason:______
Is there any other change in the child's medical or dental history that the dentist should be told?______ □ Yes □ No
Describe:______

Signature of parent/guardian:______ **Date:**______
Relationship to child:______
Signature of reviewing clinician:______ **Date:**______