UPDATED PERSONAL / HEALTH HISTORY

Madison Pediatric Dental and Orthodontics
Producing Great Smiles!
Dr. Douglas Wilson • Dr. Thomas Wenham • Dr. Grace Wenham
100 River Place, Suite 110 Madison, WI 53716
(608) 222-6160 Office (608) 222-6248 Fax
kidsdental1@madped.com www.madisonpediatricdental.com

Date________________________________

Child's Name________________________________ Nickname________________
Child's Home Address____
City State Zip
Child's Home Phone# (______) ________________ Child's Date of Birth____/____/____ Child's Age__________

Parent Information:

Name________________________________
Mother Father Guardian Foster Parent

Date of Birth____/____/____ SS#____________
Home
Address________________________________
____
City State Zip
Home # (______) ________________
Cellular Phone # (______) ________________
Email ________________________________
Employer ________________________________
Work # (_____) ____________ Ext. ________

Name________________________________
Mother Father Guardian Foster Parent

Date of Birth____/____/____ SS#____________
Home
Address________________________________
____
City State Zip
Home # (______) ________________
Cellular Phone # (______) ________________
Email ________________________________
Employer ________________________________
Work # (_____) ____________ Ext. ________

Medical History:
Has your child ever been diagnosed as having any of the following conditions? Check all that apply

Y N
☐ ☐ AIDS/HIV+
☐ ☐ Anemia
☐ ☐ Asthma Triggered by:________________
☐ ☐ Autism
☐ ☐ Cancer Type:________________
☐ ☐ Congenital Heart Defect
☐ ☐ Diabetes
☐ ☐ Epilepsy/Convulsions:
Seizures? Last date of seizure________
☐ ☐ Hearing Impairment
☐ ☐ Heart murmur
☐ ☐ Hemophilia/Bleeding disorder
☐ ☐ Hepatitis
☐ ☐ Kidney/Liver condition
☐ ☐ Learning disability
☐ ☐ Special Needs
Autism
Disabilities/Handicaps
Physical or psychological development delay
____
☐ ☐ Tuberculosis
☐ ☐ Pre-Med required for dental treatment
Reason________________________________

☐ Other________________________________
____
____

Any surgeries since last ________________________
____

Allergies (drug, environmental or latex):________________
____
____

Current medications: ________________________
____
____

Child's Physician________________________
Clinic Name________________________
Phone# (_____) ____________ Last Physical Exam? ________

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes.
I authorize the dental staff to perform any and all necessary dental treatment my child needs.

____
Parent/Legal Guardian Date