Mengedoth Dental, PC
www.drdanmengedoth.com
office@drdanmengedoth.com
2585 23rd Ave. S, Suite C • Fargo, ND 58103-6172 (701)356-1280

Youth Dental & Medical History Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Birth Date: _____

Please check one:

☐ First Dental Visit-if this is patient's first dental visit, please skip to Dental Care section.

☐ Transferred from another dental office or are updating medical history information for existing patient.

Previous Dentist

Previous Dentist's Name, Address, City, State, Zipcode, Telephone:

_____

_____

Date of last dental visit: _____

Dental Care

Frequency of dental care:

◯ Regular (every 3-6 months) ◯ Periodic (every 7-12 month) ◯ Infrequent (every 12 months)

◯ Emergency (for pain/problem management)

Please describe patient's daily oral health routine (including whether they are independent, receiving assistance, etc.):

_____

_____

Please describe any dental concerns:

_____

_____

Does the patient take fluoride in any form, including flouridated water? Please explain briefly: _____

Youth Dental & Medical History (Continued)

Please check all that apply:

- ☐ Patient has complained of dental problems or pain
- ☐ Patient has had an upsetting dental experience
- ☐ Patient seems nervous about receiving dental treatment
- ☐ Patient has experienced an injury to the mouth or head
- ☐ Patient has mouth habits (thumbsucking, nail-biting, mouth breathing, bottle, etc.)
- ☐ Patient has current health problems
- ☐ Patient is currently taking medications
- ☐ Patient is allergic to a medication or substance
- ☐ Patient has had allergic skin reaction to metal jewelry
- ☐ Patient has had an overnight hospital stay in the past 5 years
- ☐ Patient has been told they need premedication prior to dental treatment

Please explain any checked boxes above:

_____

_____

Physician Information

Date of last physical examination, Physician's Name, Address, City, State, Zipcode, Telephone:

_____

_____

Please indicate any condition which patient has had or is currently experiencing (check all that apply):

☐ A.I.D.S./H.I.V.	☐ Diabetes	☐ Liver Disease	☐ Anemia	☐ Drug/Alcohol Abuse	☐ Measels
☐ Asthma	☐ Epilepsy	☐ Mononucleosis	☐ Bladder Problems	☐ Fainting	☐ Mumps
☐ Cancer	☐ Hearing Problems	☐ Rheumatic Fever	☐ Cerebral Palsy	☐ Heart Problems	☐ Sinus Problems
☐ Chicken Pox	☐ Hepatitis	☐ Thyroid Disease	☐ Convulsions	☐ Kidney Disease	☐ Tuberculosis

Please explain any checked boxes above:

_____

_____

_____

Response Date: ____/____/_____