Special Needs Dental Medical History Form

Patient Information

Patient Name

Date of Birth

Address

Phone

Email

Emergency Contact

Emergency Contact Name

Relationship

Phone

Medical Details

Primary Physician

Physician Phone

Diagnosis / Special Needs

Current Medications (please list)

Allergies (medications, food, latex, etc.)

Hospitalizations/Surgeries (with dates)

Medical History

- [ ] Heart Problems
- [ ] Lung Problems
- [ ] Kidney Problems
- [ ] Liver Problems

- [ ] Seizure Disorder
- [ ] Diabetes
- [ ] Bleeding Disorders
- [ ] Asthma

- [ ] Autism Spectrum
- [ ] Down Syndrome
- [ ] None of the above

Other medical conditions or relevant details

Dental Information

Last Dental Visit

Previous dental experiences and any difficulties

Assistance needed for dental treatment (ex: wheelchair, communication)

Consent

Name of Guardian/Responsible Party

Date