**LEVITT & PRASATTHONG, D.D.S., P.A.**
7701 38th Ave N., St. Petersburg, FL 33710 / 727-345-3151

## Recall Medical History

**Patient Name:**________________________________

Is your child in good health? Yes____ No___
If no, explain:_____________________________________________.
Is your child up to date with physical exams? Yes___ No___
Childs Physician: ______________________ Phone: _________________
Other Doctors Groups: _________________________ Phone:______________
Has your child ever had surgery? Yes ___ No ___
If yes, what? _______________________
Any implanted items? Yes ___ No ____. If yes, list: __________________
Undergoing medical treatment? Yes ___ No ____
If yes, explain? ___________________________________________
Has your child ever been hospitalized? Yes__ No__
If yes, explain:____________________________________________
Has your child been told he/she needs antibiotics before dental appt?
Yes___ No___
Up to date on immunizations? Yes ___ No ___
Has your child received injuries to the head, jaw, mouth or teeth?
Yes___ No ____
If yes, explain: ________________________________ Date:___________

Please list any medications the patient is taking:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Does the patient have any **allergies**? Yes ___ No ___
If yes, check which ones: __ Latex __ Seasonal Allergies __Codeine
__Penicillin/Amoxicillin __Local Anesthetic __Tree Nuts
__Metals __Dyes __Sulfa __ Food :______________________
__Medications:___________________________
__Other:________________________________________
Does your child have any physical or mental disabilities? Yes__ No__
If yes, explain:___________________________________
Has your child ever had hearing, sight, speech or learning problems?
Yes__ No__
If yes, explain: _________________________________
Is your child currently receiving speech therapy? Yes__ No __
If yes, by whom:________________________________

## Medical History Continued

**Patient Name:**________________________

### Please check if your Child has had any of the following:

- __ Heart Murmur
- __ Heart Defects
- __ Heart Condition
- __ Immune Disorders
- __ Cancer/Tumors
- __ Sickle-Cell Disease
- __ Blood Disease
- __ AIDS or HIV
- __ Anemia
- __ Hepatitis (any type)
- __ MRSA/VDR
- __ Liver Disease (Jaundice)
- __ Endocrine Disorder
- __ Kidney/Bladder Disease
- __ Rheumatic Fever
- __ Hemophilia
- __ Thyroid Disease
- __ Loss of Consciousness
- __ Intellectual Disability
- __ Convulsions
- __ Psychiatric Treatment
- __ Seizures
- __ Epilepsy
- __ Emotional Problems
- __ Alcohol Dependency
- __ Chemical Dependency
- __ Hyperactivity
- __ Attention Deficit Syndrome
- __ High Blood Pressure
- __ Eating Disorder
- __ Stomach Problems (Ulcers)
- __ Sensory Disorder
- __ Autism
- __ Lung Disease
- __ Asthma
- __ Breathing Difficulties
- __ Cerebral Palsy
- __ Cleft Lip/Palate
- __ Recurrent Headaches
- __ Eye Disorders
- __ Hearing Impairment
- __ Muscle Disorders
- __ Arthritis
- __ Bone Disorder
- __ Diabetes
- __ Glandular Problems
- __ Skin Disease
- __ Tuberculosis
- __ Syndrome

## Dental Update

Has your child bumped any teeth? Yes__ No__
If yes, when?______________ How?___________________
Is your child having any dental problems at this time? Yes__ No__
If yes, explain: ______________________________
Do you have any questions or comments?________________________

## Consent

As a minor child, it is necessary that signed permission be obtained from a parent or legal guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs and photos which may be used for clinical and educational purposes. Protective restraints are used only when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health or his/her medications change, I will inform the doctor at the next appointment without fail. I will be responsible for the cost of this dental care. For specific procedures, further information will be provided.

____________________________ ____________________________
**Parent/Legal Guardian** **Date**

____________________________ ____________________________
**Print Name** **Relationship**

# Levitt & Prasatthong, D.D.S., P.A.

**Patient Name:**_______________________

**Parents name:**___________________________________________
**Address:**_______________________________________________
**City:**_________________ **State:**_______ **Zip:**_____________
**Phone 1:**___________________ **Description:**_____________
**Phone 2:**___________________ **Description:**_____________

## Medical /Dental Release Statement

I give my consent for Drs. Levitt and Prasatthong and staff to do a complete and thorough examination on the patient named, including any diagnostic x-rays needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest confidence. Furthermore, I understand that it is my responsibility to inform the doctors and staff of any changes in my child's health history. I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

___________________________________ ____________

**Signature of Parent/Legal Guardian** **Date**

# Levitt & Prasatthong, D.D.S., P.A.

**Patient Name:**______________________

Do you have any dental concerns for your child?

Yes__ No__
If yes, explain:____________________________

We take dental x-rays only when needed to check in between teeth for cavities that cannot be seen visually or to check for the development of permanent teeth. We take significant measures to limit how often x-rays are taken and to limit the amount of radiation needed for each x-ray.

Is it OK to take x-rays to check for cavities between the teeth or for development purposes?

Yes__ No__

Recently, insurance companies have started to decrease the number of times per year they will cover the cost of fluoride treatments. This is a way for insurance companies to decrease costs and is not related to dental health.

Fluoride is a very effective way to strengthen the enamel and increase resistance to dental decay. Research has shown that fluoride treatments every 6 months decrease dental decay better than just once per year. Fluoride helps re-calcify areas of enamel that have become de-calcified by leaving plaque on the teeth.

We normally do a fluoride treatment every six months when we clean your child's teeth. Do you consent to your child having their fluoride treatment today?

Yes__ No__

____________________________________ ________________
**Signature of Parent/Legal Guardian** **Date**