CHILD DENTAL / MEDICAL HISTORY

Patient's Name: ____ Date of Birth: ___________

Last First MI Nickname

Parent / Guardian's Name: ____

Dental History – Circle the appropriate answer

Yes No 1. Is this your child's first visit to the dentist? If not, how long since the last dental visit? ________________

Yes No 2. Were any x-rays or radiographs taken on your child at their previous dentist?

Yes No 3. Does your child eat between meals?

Yes No 4. Does your child eat sweets such as candy, soda pop, chewing gum?

Yes No 5. Have any cavities been noted in the past?

Yes No 6. Has your child had any problem with dental treatment in the past?

Yes No 7. Has anyone in the family, including parents, had orthodontics?

Yes No 8. Has your child ever received local anesthetic?

Yes No 9. Has your child ever had sealants placed on the biting surfaces of his/her back teeth?

Yes No 10. Does your child think there is anything wrong with his/her teeth?

Yes No 11. Has your child ever had a problem with thumb or finger sucking?

Yes No 12. Have their ever been any injuries to the teeth such as falls, blows, or chips, etc? If yes, please explain
____

Yes No 13. Were any teeth (baby or permanent) removed by extraction? If yes, was it suggested that the space be Maintained? Yes / No Was an appliance placed? Yes / No

Yes No 14. Does your child's primary source of water come from a filtered source, i.e., bottled, reverse osmosis, or other home filtration system?

15. Does your child receive fluoride in any of the following: Community Water ______ Well Water _____ Fluoride drops or tablets _____ Fluoride rinse or gel _____

16. When does your child brush his/her teeth? Upon waking ________ After eating any food ________ Right after meals _____ Before going to bed _____ Is there any regular flossing? Yes_____ No _____

Medical History

Yes No 1. Does your child have a health problem? Please explain ____________________________________

Yes No 2. Is your child under the care of a physician? If yes, since when and why? __________________________
____

3. Name of Physician: ___________________________ Phone #: ________________________

Yes No 4. Is your child receiving any prescription medication or over the counter drugs? Please list _______________
____

Yes No 5. Is your child allergic to Penicillin or any other drug? Please list _______________________________

Yes No 6. Does your child have any other allergies? Please list ___________________________________

Yes No 7. Has your child had any serious illness? When _________________ What ______________________

Yes No 8. Has your child ever had surgery?

Yes No 9. Does your child have a heart murmur or other heart problems?

Yes No 10. Does your child experience severe or prolonged bleeding?

Yes No 11. Does your child have any behavioral / learning problems?

Yes No 12. Does your child experience frequent headaches?

13. Does your child have a history of (circle appropriate response)

Diabetes	Asthma	Kidney Infections	Hepatitis A
Rheumatic Fever	Epilepsy	Cerebral Palsy	Hepatitis B
Congenital birth Defects	Mental Retardation	Vision Problems	Hepatitis C
Frequent Infections	HIV/AIDS	Speech Impairments	Hearing Loss
Other Kidney Problems	Liver Problems Being	Cancer	Placed on a Ventilator

Who may we thank for referring you to our office? ____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Parent's / Guardian's Signature: ________________________________ Date: ______________________