

PATIENT'S NAME: _____
(Last) (First) (MI)

DENTAL HISTORY – CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to the dentist? YES NO
2. If not, how long since the last visit? _____
3. Were any x-rays taken when your child previously visited the dentist? YES NO
4. Previous dentists name: _____
Address: _____ Phone number: _____
5. Does your child eat between meals? YES NO
6. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
7. When does your child brush his/her teeth? Upon rising? _____ After eating any food? _____
Right after meals? _____ Before going to bed? _____
8. How does your child receive fluoride? Community water? _____ (level _____ ppm)
Well water? _____ (level _____ ppm) Fluoride drops or tablets? _____ Fluoride rinse or gel? _____
9. Have any cavities been noted in the past? YES NO
10. Were any teeth (baby or permanent) removed by extraction? YES NO
Was it suggested that the space be maintained? YES NO
Was an appliance placed? YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
If so, please describe: _____
12. Has your child had any problems with dental treatment in the past? YES NO
13. Has anyone in the family, including parents, had orthodontics (braces)? YES NO
14. Has your child ever received a local anesthetic? YES NO
15. Has your child ever had sealants done on their teeth? YES NO
16. Does your child think there is anything wrong with his/her teeth? YES NO

MEDICAL HISTORY – CIRCLE THE APPROPRIATE ANSWER

1. Does your child have any health problems? YES NO
2. Is your child presently under a physicians care? YES NO Since when: _____
Please explain: _____
3. Name of Physician? _____ Phone: _____
4. Is your child receiving any medications? YES NO What medications: _____
5. Is your child allergic to penicillin, antibiotics or any other drugs? YES NO
6. Does your child have any other allergies? YES NO
7. Has your child ever had a serious illness? YES NO What illness? _____ When? _____
8. Has your child ever had surgery? YES NO What? _____ When? _____
9. Is surgery contemplated? YES NO

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING? (CIRCLE ALL THAT APPLY)

- | | | |
|-------------------------------|--------------------|---------------------------|
| AIDS/HIV Positive | Epilepsy | Kidney Problems/Infection |
| Allergies | Frequent Headaches | Mental Retardation |
| Asthma | Hepatitis | Nervous Disorders |
| Behavioral/Learning Disorders | Hearing Loss | Rheumatic Fever |
| Cancer | Heart Murmur | Severe/Prolonged Bleeding |
| Cerebral Palsy | Heart Problems | Speech Impairments |
| Congenital Birth Defects | Infections | Seizures |
| Diabetes | Liver Problems | Tuberculosis (TB) |
| Dizziness/Fainting | Lung Problems | Vision Problems |

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S (OR GUARDIAN'S) SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

CHILD DENTAL/MEDICAL HISTORY