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WELCOME!

We are pleased to welcome your child to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions we will be glad to help you.
We look forward to working with you in maintaining your child's dental health.

All questions contained in this questionnaire are strictly confidential
and will become part of your child's dental record.

Is there anything about your child that we should know or consider before working with him or her?

Name (Last, First, MI): ☐ M ☐ F	**Today's Date** / /
Nickname	**Birthday** / / **Age**
Residence **City**	**State** **Zip**
Home Phone ( )	
School	

Siblings	☐ Yes ☐ No	**Names/Ages**

Father	Mother
Marital Status ☐ Married ☐ Divorced ☐ Single Parent ☐ Legal Guardian	**Marital Status** ☐ Married ☐ Divorced ☐ Single Parent ☐ Legal Guardian
Name	**Name**
Email	**Email**
Employer	**Employer**
Work Address	**Work Address**
Work Phone **Cell**	**Work Phone** **Cell**

Care Giver	**Name**	**Cell Phone**

Whom may we thank for referring you?	**Name**	**Phone**
	Address	
	City	**State** **Zip**

PLEASE CONTINUE TO PAGE 2

What is your child's favorite:	Sport	Toy

CHILD'S DENTAL HEALTH HISTORY

Date of last dental visit	/ /	**For what reason?**
Has child complained about dental problems?	☐ Yes ☐ No	**What problem?**
Any unhappy dental experience?	☐ Yes ☐ No	**Describe the experience.**
Any injuries to mouth, teeth, or head?	☐ Yes ☐ No	**Describe the injury.**

Are there any mouth habits, such as thumb sucking, nail biting, mouth breathing, use of pacifier (please check the box)

Thumb Sucking	☐ YES ☐ NO	Nail Biting	☐ YES ☐ NO	Mouth Breathing	☐ YES ☐ NO	Use of Pacifier	☐ YES ☐ NO
If yes until what age?		If yes until what age?		If yes until what age?		If yes until what age?	

Have orthodontic appliances ever been worn?	☐ **Yes** ☐ **No**	
If yes, explain.		
Does your child brush daily?	☐ Yes ☐ No	*How often?*
Do you assist your child with tooth brushing?	☐ Yes ☐ No	*How often?*
Is Dental Floss used?	☐ Yes ☐ No	*How often?*
Do you put your child to sleep with a bottle?	☐ Yes ☐ No	*How often?*
Does your child drink fluoridated water?	☐ Yes ☐ No	

What is your child's nap schedule?

Describe your child's attitude toward dentistry?

CHILD'S GENERAL HEALTH HISTORY

Child's physician

Address	City	State	Zip

Date of last exam / / Results

PLEASE CONTINUE TO PAGE 3

CHILD'S GENERAL HEALTH HISTORY continued

Is the child under a physician's care now?	☐ Yes ☐ No	**Name of physician**	
Is there excessive bleeding when cut?	☐ Yes ☐ No		
Is the child taking any medication?	☐ Yes ☐ No	***What medication?***	
Are there emotional or behavioral issues?	☐ Yes ☐ No	*Please Explain*	
Has the child ever been hospitalized?	☐ Yes ☐ No	Date / /	*Please Explain*
Has the child ever had surgery?	☐ Yes ☐ No	Date / /	*Please Explain*
Is the child allergic to any medication?	☐ Yes ☐ No	**Which ones?**	
Is your child allergic to latex?	☐ Yes ☐ No		
Are there other allergies?	☐ Yes ☐ No	**What are they?**	

Has the child any history of or difficulty with any of the following *(please check the box)*:

☐ ADD / ADHD	☐ Chronic sinus	☐ Eyes	☐ Hearing	☐ Malignancies	☐ Thyroid
☐ AIDS – HIV	☐ Cleft Lip/Palate	☐ Fainting	☐ High Fever	☐ Mononucleosis	☐ Tonsils / Adenoids
☐ Anemia	☐ Convulsions	☐ Heart	☐ Intestinal	☐ Rheumatic Fever	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Heart Murmur	☐ Kidney	☐ Skin	☐ History of Trauma to the Face
☐ Canker Sore	☐ Epilepsy	☐ Headaches	☐ Liver	☐ Speech Disorder	☐

Please describe any current medical treatment, including drugs, pending surgery, recent injuries, or any other information we should be aware of that has not been discussed.

May we request the release of your child's medical records for our reference? ☐ Yes ☐ No

I understand that the information that I have provided is correct.
It is my responsibility to inform this office of any changes in my child's medical status.
I agree that the parent or guardian of the child is responsible for payment.

Print Name Below

I give my permission for the staff to take dental X-rays of my child. ☐ Yes ☐ No Please Initial to the right: _____

By signing below this name, I authorize the dental staff to perform all necessary dental services my child may need.

Relation to the child ☐ Mother ☐ Father ☐ Other

Signature (parent or guardian)

IN CASE OF EMERGENCY

Name of local friend or relative	Relation to child	Home Phone	Work or Cell Phone
Name of local friend or relative	Relation to child	Home Phone	Work or Cell Phone

The Parent or Guardian of the child is responsible for payment of dental services.

Thank you for completing our form!