

Your Child's Dental History and Habits

Your Child's Name _____ Nickname _____ Date _____

Welcome! So that we may provide your child with the best possible care, please complete both sides of this dental/ medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions

What is the reason for your visit today? _____

Your Child's Previous Dentist: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Date of your child's last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

How often does your child brush? _____ Floss? _____ Do you assist? Yes No

Is your child's water fluoridated? Yes No Does your child take fluoride supplements? Yes No

Does your child have any dental problems now? Yes No If yes, please describe _____

How do you think your child will do? Good Fair Poor

Has your child had difficulty with previous dental visits? . Yes No If yes, please describe _____

Has your child complained about dental problems? Yes No If yes, please describe _____

Has your child ever worn orthodontic appliances? Yes No If yes, please describe _____

Are any of your child's teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Does your child engage in:

Sucking thumb or fingers? Yes No

Chewing or biting fingernails? Yes No

Biting or sucking lips or cheeks? Yes No

Chewing hard objects (e.g., pencils)? Yes No

Grinding teeth? Yes No

Clenching jaw? Yes No

Mouth breathing? Yes No

Nursing bottle or pacifier habits? Yes No

Do your child's gums bleed or hurt? Yes No

Does your child have any pain or tenderness in the jaw joint, ear, side of face? Yes No

Do you have any special concerns about your child's dental health? Yes No If yes, please describe _____

Your Child's Medical History

Your Child's Name _____ Nickname _____ Date _____

Birth Date _____ Patient Account Number _____ Medical Alert _____

Your Child's Physician: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Is your child under the care of a physician?..... Yes No

If yes, please describe _____

Is your child taking any medications? (prescription or over-the-counter) Yes No

If yes, please describe _____

Have you ever been told your child needs antibiotics or premeds before treatment? Yes No

Does your child have any allergic (or adverse) reaction to any medication or other substance? Yes No

If yes, please list _____

Are your child's immunizations current? Yes No

List Any Hospitalizations, Surgeries, Serious Illnesses

When?

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

- | | | |
|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| AIDS/HIV positive <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital heart disease . <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies or hives <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles/Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Handicaps/disabilities <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Behavioral/Learning Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/psychological ... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic/scarlet fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Brain Injury <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart condition <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A B C (circle) .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cerebral Palsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/liver problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Other? Yes No Please specify _____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature of Parent/Guardian _____ Date _____

Dentist's Review

Dentist's Signature _____ Date _____