Patient Name: ____

Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER PLEASE WRITE

DENTAL HISTORY

1. Is this your child's first dental visit? Yes/No
2. If not, how long since the last visit to dentist? _____________
3. X-rays or radiographs taken when previously visited? Yes/No
4. Does your child eat between meals? Yes/No
5. Does your child eat sweets such as candy, soda? Yes/No
6. When does your child brush his/her teeth? ___________________________
7. How much fluoride does your child receive? _________________________
8. Have any cavities been noted in the past? Yes/No
9. Were any teeth (baby or permanent) removed by extraction? Yes/No
10. Have there been any injuries to teeth, such as chips, falls etc Yes/No
11. Has your child had any problems with dental treatments? Yes/No
12. Has anyone in family had orthodontics? Yes/No
13. Has your child ever received a local anesthetic? Yes/No
14. Has your child ever had sealants? Yes/No
15. Does your child think there is anything wrong with his/her teeth? Yes/No

Please list medications :

Please list surgeries / illnesses and dates:

MEDICAL HISTORY

1. Does your child have any health problems? Yes/No
2. Is your child under the care of physician? Yes/No
3. Name of physician ____
4. Is your child taking any medications? ______________________________
5. Is your child allergic to penicillin, antibiotics, or any other drugs? Yes/No
6. Is your child allergic/or sensitive to latex or any metals? Yes/No
7. Does your child have allergies? Yes/No
8. Has your child had any surgeries/illnesses (please list) Yes/No
9. Does your child have a heart murmur? Yes/No
10. Does your child experience severe or prolonged bleeding? Yes/No
11. Does your child have AIDS or been tested positive for HIV? Yes/No
12. Has your child had a positive Hepatitis test? Yes/No
13. Does your child experience any nervous disorders? Yes/No
    (fainting________, Seizures_______, Dizziness______)
14. Does your child have frequent headaches? Yes/No
15. Has your child a history of: (please circle) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, eyesight problems, cancer, infections, speech impairments, hearing loss, recent weight loss or gain, digestive problems.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE: ____ DATE: ___________________

CHILD DENTAL / MEDICAL HISTORY