welcome

Patient's Name _____
Last First Initial Nickname Date of Birth

Parent's Guardian's Name _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? **YES NO**
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? **YES NO**
4. Does your child eat between meals? **YES NO**
5. Does your child eat sweets, such as candy, soda pop, chewing gum? **YES NO**
6. When does your child brush his/her teeth?
   ❑ Upon arising ❑ After eating any food ❑ Right after meal ❑ Before going to bed
7. How does your child receive Fluoride?
   ❑ Community water level ____ ppm ❑ Well water level ____ ppm
   ❑ Fluoride drops or tablets ❑ Fluoride rinse or gel
8. Have any cavities been noted in the past? **YES NO**
9. 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**
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? **YES NO**
    Is so describe _____
11. Has your child had any problem with dental treatment in the past? **YES NO**
12. Has anyone in the family, including parents, had orthodontics? **YES NO**
13. Has your child ever received a local anesthetic? **YES NO**
14. Has your child ever had occlusal sealants? **YES NO**
15. Does your child think there is anything wrong with his/her teeth? **YES NO**

MEDICAL HISTORY

1. Does your child have a health problem? **YES NO**
2. Is your child under care of physician? **YES NO**
   If yes, since when and why? _____
3. Name of physician _____ phone
4. Is your child receiving any medication? **YES NO**
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? **YES NO**
6. Is your child allergic to or sensitive to any metals or latex? **YES NO**
7. Does your child have other allergies? **YES NO**
8. Has your child had any serious illness? **YES NO**
   When _____ What _____
9. Has your child ever had surgery? **YES NO**
10. Does your child have a heart murmur? **YES NO**
11. Is surgery contemplated? **YES NO**
12. Does your child experience severe or prolongated bleeding? **YES NO**
13. Does your child have AIDS or has he/she tested HIV positive? **YES NO**
14. Has your child tested positive for hepatitis? **YES NO**
15. Is your child subject to nervous disorders? **YES NO**
    ❑ Fainting? ❑ Seizures? ❑ Dizziness? ❑ Behavioral/Learning problems?
16. Does your child have frequent headaches? **YES NO**
17. Has your child had a history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, intellectual developmental disorder, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/ GUARDIAN SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

CHILD DENTAL MEDICAL HISTORY

MED. ALERT