WILLIAM E. LARSON, D.M.D.
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DATE		
PATIENT'S NAME	ATTENDING DENTIST	

FORMER DENTIST	DATE OF LAST VISIT	IS THIS YOUR CHILD'S FIRST DENTAL VISIT?	YES ☐	NO ☐
WHAT DO YOU WANT FOR YOUR CHILD TODAY?				

PLEASE ANSWER YES OR NO TO THE FOLLOWING

IS YOUR CHILD WORRIED OR APPREHENSIVE?	YES ☐	NO ☐	WAS THERE FOLLOW-UP CARE AT HOME?	YES ☐	NO ☐
ARE YOU WORRIED OR APPREHENSIVE?	YES ☐	NO ☐	WAS A LOCAL ANESTHETIC GIVEN?	YES ☐	NO ☐
WERE PREVIOUS DENTAL EXPERIENCES SATISFACTORY FOR YOUR CHILD?	YES ☐	NO ☐	WAS MEDICATION USED (i.e., SEDATIVE)?	YES ☐	NO ☐
IF NO, PLEASE EXPLAIN:			DID THE CHILD HAVE ANY REACTION?	YES ☐	NO ☐
			HAVE FLUORIDES BEEN APPLIED TO THE CHILD'S TEETH?	YES ☐	NO ☐
WERE REGULAR PREVENTIVE VISITS MADE?	YES ☐	NO ☐	IS YOUR CHILD TAKING DIETARY FLUORIDE?	YES ☐	NO ☐
WERE X-RAYS TAKEN?	YES ☐	NO ☐	HAS THE CHILD HAD A TOOTH SENSITIVITY TEST?	YES ☐	NO ☐
WERE HOMECARE INSTRUCTIONS GIVEN?	YES ☐	NO ☐	DO YOUR CHILD'S GUMS BLEED?	YES ☐	NO ☐

ARE THE CHILD'S TEETH SENSITIVE TO ANY OF THE FOLLOWING: HOT _____ COLD _____ SWEET _____ BITING PRESSURE _____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING: NAIL BITING _____ THUMB-SUCKING _____ TONGUE THRUST _____ HARD SWALLOWING _____ GRINDING TEETH _____

CHILD'S HEALTH HISTORY

CHILD'S PHYSICIAN			ADDRESS
DATE OF LAST VISIT	IS CHILD UNDER CURRENT MEDICAL TREATMENT? YES ☐ NO ☐	IF YES FOR WHAT?	

PLEASE INDICATE YES (Y) OR NO (N) TO ANY OF THE FOLLOWING CONDITIONS WHICH YOUR CHILD HAS HAD OR HAS AT THE PRESENT:

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
		ADENOIDS REMOVED			RESPIRATORY DISEASE			HEPATITIS			CEREBRAL PALSY			CHICKEN POX
		EAR INFECTIONS			HEART PROBLEMS			LIVER DISEASE			EPILEPSY			MUMPS/MEASLES
		HEARING PROBLEMS			CIRCULATORY PROBLEMS			KIDNEY DISEASE			HYPERACTIVITY			RHEUMATIC FEVER
		PAIN IN REGION OF EARS			HIGH BLOOD PRESSURE			MALIGNANCIES			EMOTIONAL PROBLEMS			SCARLET FEVER
		TONSILITIS			EXCESSIVE BLEEDING			RADIATION THERAPY			MENTAL DISORDER			
		TONSILS REMOVED			BLOOD DISEASE			BRAIN DAMAGE			FAINTING			
		ASTHMA			DIABETES			CONVULSIONS			SPEECH IMPEDIMENT			

DOES YOUR CHILD HAVE ANY ALLERGIES TO FOODS, MEDICATIONS, INSECT BITES, OR ANY OTHER ALLERGIES? PLEASE NAME THEM:

I BEING THE PARENT OR GUARDIAN OF THE ABOVE MINOR PATIENT, DO AUTHORIZE AND REQUEST THE PERFORMANCE OF DENTAL SERVICES FOR THIS MINOR; AND FURTHER, THE PERFORMANCE OF WHATEVER PROCEDURES IN THE "JUDGEMENT" OF THE DOCTOR MAY SEEM NECESSARY DURING THE PERFORMANCE OF ANY OPERATION I ALSO AUTHORIZE THE ADMINISTRATION OF ANESTHETICS OR ANALGESICS WHICH MAY BE DEEMED ADVISABLE BY THE DOCTOR

SIGNATURE _____ DATE _____ RELATIONSHIP TO YOUR CHILD: _____

Child Medical History

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