YOUR CHILD'S DENTAL HISTORY AND HABITS

Your child's name _____ Nickname _____ Date _____
Birthdate _____ Age _____

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.

What is the reason for your visit today? _____
Your child's previous dentist _____
Date of your child's last dental visit _____ Last dental cleaning _____ Last full mouth X-rays _____
How often does he/she brush? _____ Floss? _____ Do you assist? □Yes □No
Is your 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 (ie. 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 Physician: Name _____ Telephone ( ) _____
Address _____ City _____ State _____ Zip _____
MEDICAL ALERT _____
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 list _____
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?**
_____ _____
_____ _____
_____ _____

Please complete other side

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

AIDS/HIV positive	□Yes	□No	Hearing problems	□Yes	□No
Allergies or Hives	□Yes	□No	Heart condition	□Yes	□No
Anemia	□Yes	□No	Hepatitis A B C (indicate)	□Yes	□No
Asthma	□Yes	□No	Kidney/Liver problem	□Yes	□No
Behavioral/Learning Problem	□Yes	□No	Latex sensitivity	□Yes	□No
Bleeding disorder	□Yes	□No	Lung problem	□Yes	□No
Brain injury	□Yes	□No	Measles/Mumps	□Yes	□No
Cancer	□Yes	□No	Mononucleosis	□Yes	□No
Cerebral palsy	□Yes	□No	Nervous disorders	□Yes	□No
Chicken pox	□Yes	□No	Psychiatric/Psychological	□Yes	□No
Congenital heart disease	□Yes	□No	Rheumatic/Scarlet Fever	□Yes	□No
Diabetes	□Yes	□No	Sickle cell anemia	□Yes	□No
Epilepsy	□Yes	□No	Stomach problems	□Yes	□No
Handicaps/Disabilities	□Yes	□No	Tuberculosis	□Yes	□No
Hay Fever	□Yes	□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 Signature _____
Date _____