Dental History

Is this your child's first visit to the dentist? Y / N If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visit? Y / N Have there been injuries to the teeth, face or mouth? Y / N

If yes, please explain: _____

Why did you bring the child to the dentist today? _____

Does the patient use toothpaste with whitening products? Y / N

Does the child have any of the following habits:

Lip Sucking/Biting Y / N Nail Biting Y / N Nursing/Bottle Habits Y / N Thumb/Finger Sucking Y / N

Has the child ever had a serious or difficult problem associated with previous dental work? Y / N

If yes, please explain: _____

Is the child's water fluoridated? Y / N Does the child take fluoride supplements? Y / N

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD) Y / N

Does the child brush his/her teeth daily? Y / N Does the child floss his/her teeth daily? Y / N

Does the child take vitamins, if yes please circle which one: gummy chewable

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Health History

Has the child ever had any of the following conditions?

Any hospital stays Y / N If yes explain _____

Is immunization status current? Y / N

Asthma Y / N If yes, when was the last episode? _____What triggers it? _____

What medications does the child take? _____How often? _____

Handicaps/Disabilities Y / N If yes explain _____

Heart murmur Y / N If yes explain what kind _____ Is pre-medication needed? Y / N

Abnormal bleeding	Y / N	Pregnancy	Y / N	Kidney/Liver Conditions	Y / N
Cancer	Y / N	Hearing Impairment	Y / N	Rheumatic/Scarlet Fever	Y /N
Congenital Heart Disease	Y / N	Hemophilia	Y / N	Allergies to Latex	Y / N
Convulsions/Epilepsy	Y / N	Hepatitis	Y / N	Autism/Aspergeus	Y / N
ADD/ADHD	Y / N	HIV/AIDS	Y / N		

Is the patient developmentally delayed? Y / N

Please discuss any serious medical conditions the child has:_____

Please list all drugs and food allergies the child is allergic to:_____

Please list all drugs the child is currently taking: _____

Who may we thank for referring you? _____

Child's Physician: _____ Phone: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services my child may need.

_____ _____

Signature of Parent/Guardian Date

OFFICE USE

I have reviewed the medical/dental information above for the patient named herein. _____ _____

Doctor Date