



YOUR CHILD'S DENTAL HISTORY AND HABITS

Your Child's Name _____ Nickname _____ Date _____

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. Please be sure to answer individually any yes or no questions.

What is the reason for your visit today? _____

Your Child's Previous Dentist: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Date of your child's last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

How often does your child brush? _____ Floss? _____ Do you assist? Yes No

Is your child's 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 _____

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing or biting fingernails?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Biting or sucking lips or cheeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew hard objects (e.g. pencils)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing bottle or pacifier habits?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does 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

Date _____

Birth Date _____ Patient Account Number _____ Medical Alert _____

Your Child's Physician: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

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 describe _____

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?
_____	_____
_____	_____
_____	_____

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

- | | | | | | |
|--------------------|--|------------------------|--|---------------------------|--|
| Abnormal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS/HIV positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies or hives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Handicaps/disabilities | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/psychological | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic/scarlet fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/liver problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> 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's Signature _____ Date _____