

welcome

\_\_\_\_\_

PATIENT NUMBER

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 meals    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  
If 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

**COMMENTS**

[Large empty box for comments]

**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? \_\_\_\_\_  
Phone \_\_\_\_\_
- 3. Name of physician \_\_\_\_\_
- 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 prolonged 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 history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST. [ ]

MED. ALERT [ ]

**CHILD DENTAL MEDICAL HISTORY**