

--	--	--	--	--	--

PATIENT NUMBER

welcome

Patient's Name _____
Last First Initial Nickname Date of Brth

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. Does your child suck his/her thumb or fingers? YES NO
- 10. 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
- 11. Have there been any injuries to teeth, such as falls, blows, chips, etc? YES NO
If so describe _____
- 12. Has your child had any problem with dental treatment in the past? YES NO
- 13. Has anyone in the family, including parents, had orthodontics? YES NO
- 14. Has your child ever received a local anesthetic? YES NO
- 15. Has your child ever had occlusal sealants? YES NO
- 16. Does your child think there is anything wrong with his/her teeth? YES NO

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, cognitive disability, 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