Patient Name

Last First Initial

Soc. Sec. #

Birthdate

Month Day Year

COMMENTS

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 a dentist? ________________________
3. Were any **X-RAYS** or radiographs taken by another dentist? .. . . YES NO
4. Does your child eat between meals? . . . . YES NO
5. Does your child eat **SWEETS**, such as **CANDY, SODA, CHEWING GUM**?. YES NO
6. When does your child **BRUSH** his/her teeth?
7. ☐Upon arising ☐After eating any food ☐Right after meals ☐ Before bed
8. How does your child receive **FLOURIDE**?
9. Community water (level _____ ppm ____) ☐Well water (level ___ ppm ___)
10. ☐ Flouride drops or tablets ☐Flouride rinse or gel.
11. Have any **CAVITIES** been noted in the past? . . . . YES NO
12. Were any **TEETH** (baby or permanent) **REMOVED** by extraction? . . . . . . YES NO
13. Was it suggested that the space be maintained? . . . . YES NO
14. Was an appliance placed? . . . . YES NO
15. Have there been **INJURIES** to teeth such as **FALLS, BLOWS, CHIPS**, etc. YES NO
    If so, please describe: ____
16. Has your child had any **PROBLEM** with dental treatment in the past? ... . . YES NO
17. Has anyone in the family, including parents, had **ORTHODONTICS**? . . .. . . YES NO
18. Has your child ever received a **LOCAL ANESTHETIC**? . . . . YES NO
19. Has your child ever had **OCCLUSAL SEALANTS**? . . . . YES NO
20. Does your child think there is anything **WRONG** with his/her teeth? . . . . . . YES NO

MEDICAL HISTORY

1. Does your child have a **HEALTH PROBLEM**? . . . . YES NO
2. Is your child under care of **PHYSICIAN**? . . . . YES NO
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 prolongated **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___________

CHILD DENTAL MEDICAL HISTORY

Cut immediately ABOVE this line