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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 maintainedYES NO
Was an appliance placedYES 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