Patients Name (last, first) ________________________________ Nickname ______________ DOB ____________

Parents Name ________________________________ Patient's Weight __________ lbs

PLEASE CHECK ALL APPROPRIATE ANSWERS

DENTAL HISTORY

COMMENTS

- Is this the child's first visit to the dentist? ---------------------------------------YES NO
- If not, how long since the last visit? ______________________________
- Has child had previous radiographs or x-rays? ------------------------------------YES NO
- Has child complained about any dental problems? -------------------------------YES NO
- Any mouth habits? ☐ Now ☐ previously-------------------------------------YES NO
  - ☐ Thumb sucking ☐ nail biting ☐ mouth breathing ☐ pacifier
- When was the child off the ☐ bottle ☐ breast completely? ____________
- Any unusual speech habits? ---YES NO
- Does your child receive fluoride? --YES NO
  - ☐ Community water ☐ well water ☐ toothpaste
  - ☐ Fluoride drops or tablets ☐ fluoride rinse/gel
- Have there been any injuries to teeth, such as falls, blows, chips, ect.?-------YES NO

  If yes, please specify: ______________________________________
- Has your child had any unfavorable dental experiences? ------------------------YES NO
- What is your Childs attitude towards dentistry?______________________
- How many children in your family?______________________________
- Has anyone in the family, including parents, had orthodontics? ---------------YES NO
- Has child ever received a local anesthesia? --YES NO
- Do you have any specific dental concerns or questions? -------------------------YES NO

  If yes, please specify:______________________________________

MEDICAL HISTORY

- Is child in good health? ---YES NO
- Name of physician or pediatrician__________________________________
- Has child had any serious ☐ illness ☐ hospitalization-------------------YES NO

  If so, please specify(including date)______________________________

  ____
- Has child had any Surgery or have any surgery planned? ------------------------YES NO
- Is child up to date with immunizations? --YES NO
- Does child have allergies? --YES NO

  If yes, please clarify (be specific)________________________________
- Is child allergic to penicillin, antibiotics or other drugs? _____________ YES NO
- Is child receiving any medications? __________________________ YES NO
- Does your child have special needs? --YES NO

☐ Heart Murmur	☐ Asthma	☐ Anemia	☐ Cancer
☐ Heart Problems	☐ Reactive Airway Disease	☐ Bleeding Disorder	☐ AIDS/HIV
☐ Down Syndrome	☐ Allergies to Medications	☐ Blood Transfusions	☐ Mononucleosis
☐ Asperger's Syndrome	☐ Environmental Allergies	☐ Rheumatic Fever	☐ Tuberculosis
☐ Autism	☐ Food Allergies	☐ Hepatitis	☐ Bladder Problems
☐ Cerebral Palsy	☐ Chronic Sinus	☐ Thyroid Problems	☐ Dizziness/Fainting
☐ Birth Defects	☐ Diabetes	☐ Kidney Problems	☐ Hearing Loss/Vision Loss
☐ ADHD/PDD/ODD	☐ Epilepsy/Seizures	☐ Liver Problems	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

MED ALERT

Patients or Guardians Signature:__________________________ Date: __________

Dentist Signature: ________________________________ _ Date:__________

ANEST.

CHILD DENTAL MEDICAL HISTORY