YOUR CHILD'S DENTAL HISTORY & HABITS

Welcome! So that we may provide your child with the best possible care, please complete **ALL PAGES** of this **Dental/Medical History Forms.** Please be sure to answer individually and **yes** or **no** questions.

Your Child's Name _____ **Nickname** _____ **Date** _____

What is the reason for your visit today? _____

_____

Your Child's Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

Date of Your Child's Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

How often does your child brush? _____ Floss? _____ Do you assist? **YES NO** *(please circle one)*

Is your child's water fluoridated? **YES NO** Does your child take fluoride supplements? **YES NO**

Does your child have any dental problems now? **YES NO** If yes, please describe _____

_____

How do you think your child will do? **GOOD FAIR POOR**

Has your child had difficulty with previous dental visits? **YES NO** If yes, please describe _____

Has your child complained about dental problems? **YES NO** If yes, please describe _____

Has your child ever worn orthodontic appliances? **YES NO** If yes, please describe _____

Are any of your child's teeth sensitive to:

Hot or Cold? **YES NO** Sweets? **YES NO** Biting or Chewing? **YES NO**

Does your child engage in:

Sucking thumb or fingers? **YES NO**

Biting or sucking lips or cheeks? **YES NO**

Grinding teeth? **YES NO**

Mouth breathing? **YES NO**

Chewing or biting fingernails? **YES NO**

Chewing hard objects *(e.g. pencils)*? **YES NO**

Clenching jaw? **YES NO**

Nursing bottle or pacifier habits? **YES NO**

Does your child's gums bleed or hurt? **YES NO**

Does your child have any pain or tenderness in the jaw joint, ear, side of face? **YES NO**

Do you have any special concerns about your child's dental health? **YES NO**

If yes, please describe _____

_____

_____

YOUR CHILD'S MEDICAL HISTORY

Welcome! So that we may provide your child with the best possible care, please complete **ALL PAGES** of this **Dental/Medical History Forms.** Please be sure to answer individually and **yes** or **no** questions.

Your Child's Name _____ **Nickname** _____ **Date** _____

Date of Birth _____ **Patient Account Number** _____ **Medical Alert** _____

Your Child's Physician Name _____ Telephone _____

Address _____ State _____ Zip _____

Is your child under the care of a physician? **YES NO** If yes, please describe _____

Is your child taking any medications? *(prescription or over-the-counter)* **YES NO** If yes, please describe _____

Have you ever been told your child needs antibiotics or premeds before treatment? **YES NO**

Does your child have any allergic *(or adverse)* **reaction to any medications or other substance?** **YES NO** If yes, please list _____

Are your child's immunizations current? **YES NO**

List any Hospitalizations, Surgeries, Serious Illnesses **When**

Indicate which of the conditions your child has now or ever has had. Circle each answer individually.

AIDS/HIV Positive	YES	NO	Diabetes	YES	NO	Mononucleosis	YES	NO
Allergies or Hives	YES	NO	Epilepsy	YES	NO	Nervous Disorders	YES	NO
Anemia	YES	NO	Handicaps/Disabilities	YES	NO	Psychiatric/Psychological	YES	NO
Asthma	YES	NO	Hay Fever	YES	NO	Rheumatic/Scarlet Fever	YES	NO
Behavioral/Learning Problem	YES	NO	Hearing Problem	YES	NO	Sickle Cell Anemia	YES	NO
Bleeding Disorder	YES	NO	Heart Condition	YES	NO	Stomach Problems	YES	NO
Brain Injury	YES	NO	Hepatitis **A B C** *(circle one)*	YES	NO	Tuberculosis	YES	NO
Cancer	YES	NO	Kidney/Liver Problems	YES	NO	**Other?** *please specify*	YES	NO
Cerebral Palsy	YES	NO	Latex Sensitivity	YES	NO			
Chicken Pox	YES	NO	Lung Problems	YES	NO			
Congenital Heart Disease	YES	NO	Measles/Mumps	YES	NO			

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you will have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my child's health or medication.

Signature of Parent or Guardian _____ **Date** _____

DENTIST'S REVIEW

Dentist Signature _____ Date _____