

Dental History

First Name: _____ Last Name: _____ Date of Birth: _____

Is the child currently in pain? Yes No What is the primary reason for today's visit? _____

Has the child experienced problems with previous dental work? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Previous Present Dentist: _____ Date of Last Visit: _____

Why did you leave your previous dentist?: _____

What did you *like* most about any dentist you have seen?: _____

What did you *dislike* most about any dentist you have seen?: _____

Does/did the child have any of the following habits?

Yes No Lip Sucking/Biting

Yes No Clenching/Grinding Teeth

Yes No Tongue/Cheek Biting

Yes No Mouth Breather

Yes No Nail Biting

Yes No Thumb/Finger Sucking

Yes No Used Pacifier

Yes No Speech Problems

Yes No Chewing on Objects

Yes No Nursing Bottle Habits

Yes No Tongue Thrust

Yes No Breast Fed

Medical History

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

Address: _____

Is the child currently under the care of a physician? Yes No Please explain: _____

Please describe the child's current physical health: Good Fair Poor *Are immunizations current?* Yes No

Please list all of the drugs that the child is currently taking: _____

Is your child allergic to any of the following: Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Does your child have any medical conditions that require Pre-Med? Yes No

Has the child had/experienced any of the following:

Yes No Abnormal Bleeding

Yes No Congenital Heart Defect

Yes No High Blood Pressure

Yes No Rheumatic Fever

Yes No AIDS/HIV+

Yes No Convulsions

Yes No Hives

Yes No Scarlet Fever

Yes No Allergies

Yes No Diabetes

Yes No Kidney Problems

Yes No Sickle Cell Anemia

Yes No Anemia

Yes No Epilepsy

Yes No Liver Problems

Yes No Skin Rash

Yes No Any Hospital Stay/Operations

Yes No Handicaps/Disabilities

Yes No Low Blood Pressure

Yes No Tonsillitis

Yes No Asthma

Yes No Hearing Impairment

Yes No Lupus

Yes No Tuberculosis (TB)

Yes No Blood Transfusion

Yes No Heart Murmur

Yes No Measles

Yes No Cancer

Yes No Hemophilia

Yes No Mitral Valve Prolapse

Yes No Chicken Pox

Yes No Hepatitis

Yes No Mononucleosis

Please discuss any serious medical problems the child experiences/ed: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor to all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

If you understand the above and all of your questions have been answered, check here:

Name: _____ Date: _____