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PATIENT NUMBER

welcome

Patient's Name \_\_\_\_\_  
Last First Initial Nickname Date of Birth

Parent's Guardian's Name \_\_\_\_\_

**DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER**

- Is this your child's first visit to a dentist? .....YES NO
- If not, how long since the last visit to the dentist? \_\_\_\_\_
- Were any x-rays or radiographs taken when your child previously visited the dentist? ...YES NO
- Does your child eat between meals? .....YES NO
- Does your child eat sweets, such as candy, soda pop, chewing gum? .....YES NO
- When does your child brush his/her teeth?  
 Upon arising     After eating any food     Right after meals     Before going to bed
- How does your child receive Fluoride?  
 Community water level \_\_\_\_ ppm     Well water level \_\_\_\_ ppm  
 Fluoride drops or tablets     Fluoride rinse or gel
- Have any cavities been noted in the past? .....YES NO
- Does your child suck his/her thumb or fingers? .....YES NO
- Were any teeth (baby or permanent) removed by extraction? .....YES NO  
 Was it suggested that the space be maintained .....YES NO  
 Was an appliance placed .....YES NO
- Have there been any injuries to teeth, such as falls, blows, chips, etc? .....YES NO  
 If so describe \_\_\_\_\_
- Has your child had any problem with dental treatment in the past? .....YES NO
- Has anyone in the family, including parents, had orthodontics? .....YES NO
- Has your child ever received a local anesthetic? .....YES NO
- Has your child ever had occlusal sealants? .....YES NO
- Does your child think there is anything wrong with his/her teeth? .....YES NO

**COMMENTS**

**MEDICAL HISTORY**

- Does your child have a health problem? .....YES NO
- Is your child under care of physician? .....YES NO  
 If yes, since when and why? \_\_\_\_\_  
Phone \_\_\_\_\_
- Name of physician \_\_\_\_\_
- Is your child receiving any medication? .....YES NO  
 What? \_\_\_\_\_
- Is your child allergic to penicillin, antibiotics or other drugs? .....YES NO
- Is your child allergic to or sensitive to any metals or latex? .....YES NO
- Does your child have other allergies? .....YES NO
- Has your child had any serious illness? .....YES NO  
 When \_\_\_\_\_ What \_\_\_\_\_
- Has your child ever had surgery? .....YES NO
- Does your child have a heart murmur? .....YES NO
- Is surgery contemplated? .....YES NO
- Does your child experience severe or prolonged bleeding? .....YES NO
- Does your child have AIDS or has he/she tested HIV positive? .....YES NO
- Has your child tested positive for hepatitis? .....YES NO
- Is your child subject to nervous disorders? .....YES NO  
 Fainting?     Seizures?     Dizziness?     Behavioral/Learning problems?
- Does your child have frequent headaches? .....YES NO
- 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 \_\_\_\_\_

ANEST.

MED. ALERT

**CHILD DENTAL MEDICAL HISTORY**