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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

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?
Was it suggested that the tooth be maintained? YES NO
Was an appliance placed? YES NO
11. Have there been any injuries to teeth, such as fall, blows, chips, etc? YES NO
If so describe _____
12. Has your child had any previous 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

**COPY COURTESY OF THE DENTAL RECORD
TO ORDER CALL (800) 243-4675
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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 spinal 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, 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