Patient Name: _____

## DENTAL HISTORY

Is this your child's first visit to the dentist YES/NO If no, date of last visit and x-rays taken _____
Name of previous dentist/location and reason for change in dentist_____
Any unhappy dental experiences YES/NO If Yes please explain_____
Child's attitude about dentistry_____
What can we do to make this visit awesome for you and your child_____
Reason for today's visit_____
Do you expect your child to cooperate for exam YES/NO
Have there been any injuries to the teeth, face, mouth or Head? YES/NO If yes explain _____

_____

Any mouth habits? ☐ Currently ☐ Previously ☐ Never
(circle) finger, thumb, pacifier, tongue thrust, bruxism, mouth breather, other_____
Is child currently breast/bottle fed YES/NO If no at what age discontinued? _____

## MEDICAL HISTORY

Is child's water fluoridated YES/NO Source of drinking water: city, well, bottled or other_____
Is child taking fluoride vitamins YES/NO Gummy vitamins YES/NO Do you help your child brush and floss YES/NO
Does your child have a high sugar diet (candy, soda, juice, sports drinks) YES/NO _____
Has an Orthodontist been consulted YES/NO Name of Orthodontist: _____
Reason for orthodontic consult_____
Any unusual speech habits YES/NO ☐ Lisp ☐ Pronunciation ☐ Delay ☐Other _____

Is child in good health YES/NO Date of last medical exam_____ Results _____
Are immunizations up to date YES/NO
Does child require Antibiotic pre-medication before dental procedures YES/NO if yes, explain_____
Has child had any surgery, hospitalizations or emergency room visits YES/NO If yes, Date_____ Please explain_____
_____
Does your child function at their appropriate age level? YES/NO If no, explain_____

## Has your child ever had any of the following (circle all that apply or circle "None"):

Abnormal bleeding/bruising
ADD/ADHD/PDD: Meds:_____
_____
AIDS/HIV
Anemia
Asthma/Reactive Airway Disease
Arthritis
Autism Spectrum Disorder
type_____
Allergic to foods list below
Allergies list below
Autoimmune disorders
Behavioral/Learning Disorders
Behavioral/Emotional Problems
Blood Disorders
Blood Transfusion date_____
Brain Injury explain below
Cancer/Tumors
Chemotherapy/Radiation
Cerebral Palsy type_____
Chronic ear/sinus infections
Cleft Palate/Lip
Congenital Birth Defects
Congenital Genetic Defects
Congenital Heart Disease
Convulsions/Epilepsy/Seizures
Developmental Delays/Disorders
Diabetes
Emotional condition or disorder
Diagnosis_____
Endocrine Disorder
Eye/Vision Problems
Gastrointestinal Problems/Reflux
Genetic Disorder: Type: _____
_____
Handicaps/Disabilities
Hearing Impairment
Headaches/Migraines
Heart Murmur
Does murmur require antibiotic
premedication_____

Heart Disease
Hemophilia
Hepatitis
Infections(viral/bacterial)
Kidney/Liver Problems
Latex Allergy
Lactose Intolerant
Learning Problems
Lung Problems/Cystic Fibrosis
Mental/Nervous Disorder
MRSA Infection
Psychological Disorder
Premature Birth/Defects
Pneumonia
Rheumatic Fever
Sinus Problems
Sickle Cell Anemia/Trait
Sleep Apnea/Snoring
Speech Disorder
Spina Bifida
Tonsil/Adenoid Problems
Transplants
Tuberculosis
Thyroid Disorder
TMJ/TMD
NONE

## Other Medical Conditions (explain below)

_____

_____

_____

**Patient Name: _____**

**Please discuss in detail any medical problems or allergies child has_____**

**_____**

**Has Child taken frequent liquid medications i.e.-antibiotics, allergy medications, etc. YES/NO**

**If yes please list_____**

**Please list all medications child is currently taking _____**

**_____**

**Please list all Food or medications your child is allergic to:**

**_____**

**_____**

**Has your child had any problems with general or local anesthesia? YES or NO**

**If yes, please explain: _____**

**_____**

**I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status. I give permission to the dentist and auxiliaries to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.**

**Signature of Parent/Guardian_____ Relationship to Patient _____Date_____**

**Name of person completing this form_____ Relationship to Patient_____Date_____**