Patient Name: _____ Birth Date: _____

Today's Date: _____ Phone#: _____

Reason for today's visit: **(please circle)** Routine Emergency Consultation

Child's Dental History

Y N Is this your child's first dental visit? If no, describe below what treatment was received at previous dentist?

_____

Previous Dentist: _____ City: _____ Ph: _____

Please circle YES or NO if your child has:

Y N Ever received fluoride? (please circle) Fluoride tablets Rinses Dental office
Y N Ever gone to the dentist with pain, infection or injury?
Y N Ever had experience with Nitrous Oxide (laughing gas) or oral sedatives?
Y N Ever been fearful of physicians or dentist due to a frightening experience?
How many times per day does your child brush? _____ Floss? _____
If child is under 6, do you brush your child's teeth or assist with brushing? _____
What is your estimation of your child's dental health: **(please circle)** Good Fair Poor

Please circle any of the following habits your child exhibits:

Thumb/finger sucking Lip sucking/lip biting Nail biting/pencil biting Tongue thrusting Mouth breathing Heavy snoring/teeth grinding

Child's Medical History

Child's Physician: _____ Phone: _____

Address: _____ Date last seen: _____

Y N Has your child had surgery or been hospitalized? _____

Y N Is your child being treated by a physician for any reason other than routine? _____

Y N Is your child taking any medications? Please list: _____

List any allergies to medication, food or metal: _____

Please circle YES or NO if you child has had any of the following disease, conditions or procedures

Y N Abnormal bleeding
Y N Anemia
Y N Artificial heart valves
Y N Asthma/breathing problems
Y N Autism/PDD
Y N Birth defects
Y N Blood transfusion(s)
Y N Cancer/Leukemia/tumors
Y N Cerebral Palsy
Y N Chemotherapy
Y N Cleft lip/palate
Y N Congenital heart defect
Y N Developmental delay/Downs Syndrome
Y N Diabetes (Type__) Hypoglycemia
Y N Eye, ear and nose problems
Y N Fainting/seizures/epilepsy
Y N Heart murmur/heart disease
Y N Hemophilia
Y N Hepatitis (Type___)
Y N High/Low blood pressure
Y N HIV/AIDS/ARC
Y N Hyper active/ADD/ADHD
Y N Jaundice
Y N Jaw problems TMJ/TMD
Y N Latex allergy
Y N Liver/Kidney/Organ Problems
Y N Premature birth
Y N Psychiatric problems
Y N Reactive Attach Disorder
Y N Respiratory problems
Y N Rheumatic fever
Y N Scarlet Fever
Y N Scoliosis
Y N Surgeries/operations
Y N Tonsils/adenoids
Y N Tuberculosis

If YES explain: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes.

_____ _____

Signature of parent/guardian **Date** **Signature of dentist** **Date**