Patient's Name: _____

Last First Initial Nickname Birthdate

Previous Dentist: _____

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. How was your child's previous experience? _____
4. Were any x-rays or radiographs taken when your child previously visited the dentist? ..... YES NO
5. Does your child eat between meals? ..... YES NO
6. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
7. When does your child brush his/her teeth?
   ☐ Upon rising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
8. Do you help brush or supervise their brushing? ..... YES NO
9. How does your child receive Fluoride?
   ☐ Community water level _____ppm ☐ Well water level ____ ppm
   ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
10. Have any cavities been noted in the past? ..... YES NO
11. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
12. Was it suggested that the space be maintained? ..... YES NO
13. Was an appliance placed? ..... YES NO
14. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... YES NO
    If so, describe: _____
15. Has your child had any problem with dental treatment in the past? ..... YES NO
16. Has anyone in the family, including parents, had orthodontics? ..... YES NO
17. Has your child ever received a local anesthetic? ..... YES NO
18. Has your child ever had occlusal sealants? ..... YES NO
19. Does your <u>child</u> think there is anything wrong with his/her teeth? ..... YES NO

MEDICAL HISTORY

1. Does your child have any health problems? ..... YES NO
2. Is your child under the care of a physician? ..... YES NO
   If yes, since when and why? _____
3. Name of physician _____
4. Is your child receiving any medication? ..... YES NO
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?
   When _____ What _____
9. Has your child ever had surgery? ..... YES NO
10. Does your child experience severe or prolonged bleeding? ..... YES NO
11. Does your child have AIDS or has he/she tested HIV positive? ..... YES NO
12. Is your child subject to nervous disorders? ..... YES NO
    ☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?
13. Does your child have frequent headaches? ..... YES NO
14. Has your child had history of (circle appropriate responses): diabetes, heart trouble, asthma, kidney trouble, epilepsy, cerebral palsy, liver problems, mentally impaired, eyesight problems, cancer, infections, speech impairments, hearing loss, hepatitis, attention deficit disorders, pregnancy, congenital birth defects.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT/GUARDIAN'S SIGNATURE _____ DATE _____

CHILD DENTAL/MEDICAL HISTORY