

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Medical History

	<b>Yes</b>	<b>No</b>
Does your child have any major health problems?.....	___	___
If yes, please explain. _____		
Has your child been hospitalized?.....	___	___
If yes, please explain. _____		
Have you ever been told that your child has a heart murmur? .....	___	___
If yes, please explain. _____		
Is your child currently being treated by a physician? .....	___	___
If yes, please explain. _____		
Does your child suffer from any allergies? .....	___	___
If yes, please explain. _____		
Has your child ever experienced an unfavorable reaction to drugs, including antibiotics? Or local anesthetics?.....	___	___
If yes, please explain. _____		
What medications is your child currently taking? _____		
Does your child have a history of developmental or behavioral problems? .....	___	___
___ Above Average    ___ Average    ___ Below Average    ___ Learning Disabled		

Has or does your child have a history or difficulty with any of the following? (please circle)

AIDS	Chronic Sinus	Liver/Hepatitis
Attention Deficit Disorder	Diabetes	Malignancies/Cancer
Asthma	Down Syndrome	Rheumatic Fever
Autism	Ears/Hearing	Seizures/Epilepsy
Bleeding Disorders	Heart	Thyroid
Cerebral Palsy	Kidneys	Tuberculosis
Other _____		

Child's Physician \_\_\_\_\_ Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

Specialist \_\_\_\_\_ Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

### Dental History

Last visit to the dentist: Date \_\_\_\_\_ Dentist \_\_\_\_\_ Services Rendered \_\_\_\_\_

What was your child's behavioral response to past dental or medical care? \_\_\_\_\_

Does your child have dental complaints? \_\_\_ Yes \_\_\_ No

    If yes, please explain. \_\_\_\_\_

Any injuries to the teeth, mouth, or head? \_\_\_\_\_

Any history of the following?    \_\_\_ Headaches    \_\_\_ Bruxism (Grinding)    \_\_\_ TMJ/Joint problems  
  \_\_\_ Swelling    \_\_\_ Pain

Any history of the following?    \_\_\_ Thumb sucking    \_\_\_ Finger sucking    \_\_\_ Pacifier    \_\_\_ Lip biting  
  \_\_\_ Nail Biting        \_\_\_ Bottle/Nursing after 12-14 months

Does your child brush daily?    \_\_\_ Yes \_\_\_ No        Does your child floss? \_\_\_ Yes \_\_\_ No

Do you assist your child when:    Brushing \_\_\_ Yes \_\_\_ No        Flossing \_\_\_ Yes \_\_\_ No

Is fluoride taken in any form?    \_\_\_ Water (fluoride level \_\_\_ )    \_\_\_ Toothpaste    \_\_\_ Fluoride drops  
  \_\_\_ Chewable tablets                \_\_\_ Rinse

What is your child's attitude toward dentistry? \_\_\_\_\_

Do you desire complete dental service for your child? \_\_\_ Yes \_\_\_ No

    If no, please explain \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian \_\_\_\_\_

Date \_\_\_\_\_