

Dental History

Date of last visit to a dentist _____
For what service? _____ Please Circle
Has child complained about dental problems? _____ Yes No
Any unhappy dental experiences? _____ Yes No
Any injuries to mouth-teeth-head? _____ Yes No
Any mouth habits? Thumb sucking, nail biting, pacifier, nursing bottle habits _____ Yes No
Mouth breathing, etc. _____ Yes No
Any unusual speech habits? _____ Yes No
Any lost teeth (other than natural eruption)? _____ Yes No
Have any missing teeth been replaced? _____ Yes No
Orthodontic appliances worn now or ever? _____ Yes No
Does your child brush teeth daily? _____ Yes No
Do you assist your child with tooth brushing? How often? _____ Yes No
Is dental floss used? ___ How often? _____ Yes No
Is fluoride taken in any form? _____ Yes No
Do you desire complete dental service for your child? _____ Yes No
Child's attitude toward dentistry? _____

Health History

Child's physician _____ Address _____
Date of last physical? _____ Results _____
Is child under care of physician now? _____ Yes No
Is child receiving any medications or drugs? _____ Yes No
Is there any excessive bleeding when cut? _____ Yes No
Has child ever been hospitalized? _____ Yes No
Is there any allergy to penicillin or other medications? _____ Yes No
Are there other allergies: Food-pollen-animals-dust? _____ Yes No
Are there any emotional problems? _____ Yes No
May we request the release of your child's medical records for our reference? _____ Yes No
Has child any history of, or difficulty with any of the following:

| | | |
|-----------------------|-------------------------|---------------|
| _____ Anemia | _____ Chronic Sinus | Hearing _____ |
| _____ Asthma | _____ Convulsions | Heart _____ |
| _____ Bladder | _____ Diabetes | Kidney _____ |
| _____ Cerebral Palsy | _____ Epilepsy | Liver _____ |
| _____ Chicken Pox | _____ Fainting | Cancer _____ |
| _____ Mononucleosis | _____ AIDS/HIV Positive | Measles _____ |
| _____ Tuberculosis | _____ Thyroid | Mumps _____ |
| _____ Rheumatic Fever | | |

FEMALE: Are you pregnant? Yes No If yes, month due _____ Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.

I have answered all questions truthfully and to the best of my knowledge.

Parent/guardian signature _____ Date _____