Patient's Name ______________________ DOB ___________________ Today is ____________________

Patient Dental History

Please answer the following questions:

Has your child been to any dental office in the last six months? Yes/No

If yes, what was the dentist's name? ____

If yes, when was the visit and what was done? ____

Has your child ever had dental X-rays? Yes/No If yes, when? ____

Has your child ever had problems with dental anesthetics? Yes/No If yes, explain: _______________________________

Do you expect your child to be a cooperative dental patient? Yes/No If no, explain: _______________________________

Please rate your child's comfort level with receiving dental treatment: Comments: _________________________________

( ) Unknown ( ) No Problem ( ) Slightly Anxious ( ) Moderately Anxious ( ) Fearful

REASON FOR VISIT

( ) Routine Visit ( ) Cosmetic ( ) Habit ( ) Orthodontic ( ) Behavior ( ) Education ( ) Decay ( ) Physical/Mental Handicap

( ) Emergency ( ) Other: ____

Does your child have or has had any of the following?

- Thumb sucking Yes/No How Long? ___________________ Still active? Yes/No
- Finger Habit Yes/No How Long? ___________________ Still active? Yes/No
- Pacifier Yes/No How Long? ___________________ Still active? Yes/No
- Dental Trauma Explain: ____

Does your child clench or grind their teeth? Yes/No If yes, explain: ____

Does your child sleep with a bottle at night? Yes/No If yes, explain: ____

Does your child's bottle or sippy cup contain fluid other than milk or water? Yes/No If yes, explain: ___________________

Does your child use fluoride toothpaste? Yes/No If no, explain: ____

PREVENTATIVE

How often does your child brush? ____________________________ Does your child floss their teeth? Yes/No

Is tooth brushing and flossing supervised? Yes/No By whom? ____

Does your child drink: ( ) Fluoridated water- city or county ( ) Bottled water ( ) Filtered Water ( ) Well water

Does your child take: ( ) Fluoride in vitamins ( ) Fluoride in tablets/drops Other: ____________________

Patient's name: ______________________ DOB ___________________ Today is ___________________

Medical History

Is your child presently under the care of a ( ) Pediatrician or ( ) Family Physician

For specific medical reason? Yes/No If yes, explain: ____

Physician's name ________________________________ Contact # ____

Date of last medical exam ________________________

Is your child in good health? Yes/No If no, explain: ____

Is your child taking any medications at this time? Yes/No If yes, list ____

Has your child ever been hospitalized? Yes / No

If yes, when and for what reason? ____

a. Does your child have any of these conditions? ( ) Heart Murmur ( ) Pins ( ) Plates ( ) None
b. If so, has your child been instructed to be pre-medicated for this or other condition? Yes / No

Is your child up to date with immunizations? Yes/No

Is your child allergic to any medication? Yes/No If yes, explain: ___________________________________

Does your child have any allergies? Yes/No

Have you ever been told that your child needs premedication

for a heart condition before dental treatment? Yes/No If yes, explain: _______________________________

Has your child's tonsils and/or adenoids been removed? Yes/No If yes, explain: _______________________________

CHECK ANY OF THE FOLLOWING THAT MAY PERTAIN TO YOUR CHILD:

____ Anemia	____ Cleft Lip / Palate	____ Hearing Loss	____ Cognitive Delay
____ Attention Deficit disorder	____ Convulsion / Seizures	____ Heart Disease	____ Nutritional Deficiency
____ Allergy	____ Diabetes	____ Hemophilia	____ Orthopedic Problem
____ Autism	____ Emotional Disturbance	____ Hepatitis-Type_____	____ Rheumatic Fever
____ Asthma	____ Epilepsy	____ Heart Murmur	____ Sickel Cell Anemia
____ Brain Injury	____ Eye Problems	____ Hyperactivity	____ Spina Bifida
____ Cancer	____ Excessive Bleeding Problem	____ Jaundice	____ Syndrome
____ Cerebral Palsey	____ Fainting	____ Leukemia	Other __________________

____________ **None of the above**

Explain any items checked above:

____

X____ ____________________ _________________

Signature of person completing form Relationship to Patient Date