



Your Child

First & Last Name _____ Preferred Name _____

Date of Birth _____

Age _____ Sex _____ SS# _____ School _____

Grade _____ Child's home address _____

City, State, and Zip _____

Medical History

Does your child have any major health problems? Yes ___ No ___

If yes, please explain _____

Has your child been hospitalized? Yes ___ No ___

If yes, please explain _____

Have you ever been told that your child has a heart murmur? Yes ___ No ___

If yes, please explain _____

Is your child currently being treated by a physician? Yes ___ No ___

If yes, please explain _____

What medications is your child currently taking? Are they taken in AM or PM?

Does your child suffer from allergies? Yes ___ No ___

If yes, please explain _____

Does your child have asthma Yes ___ No ___

If yes, what initiates symptoms/attack? _____

Has your child ever experienced an unfavorable reaction to drugs, including antibiotics, or local anesthetics? Yes ___ No ___

If yes, please explain _____

Does your child have developmental or behavioral problems? Yes ___ No ___

If yes, please explain _____

How would you classify your child's ability to learn?
___ Above Average ___ Average ___ Below Average ___ Learning Disabled

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

ADD/ADHD	Diabetes	Malignancies/Cancer
Asthma	Ears/Hearing	Rheumatic Fever
Bleeding Disorders	Heart	Seizures/Epilepsy
Cerebral Palsy	HIV+	Thyroid
Cleft Lip/Palate	Kidneys	Tuberculosis
Chronic Sinus	Liver/Hepatitis	Other_____

Child's Physician _____ Address _____ Phone # _____
In case of an emergency, name of friend or relative _____ Phone # _____

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 complications Yes _____ No _____

If yes, please explain _____

Any injury to the teeth, mouth, or head? _____

Any history of the following? (circle) Headaches Bruxism TMJ/Joint problems

Swelling Pain

Does your child have any Habits, Past or Current?

Thumb sucking Finger sucking Pacifier Lip biting Frequency _____

Does your child brush daily? Yes _____ No _____

Do you assist your child with brushing? Yes _____ No _____

Do you assist your child with flossing? Yes _____ No _____

Does your child take fluoride in any form? (Circle) Water Toothpaste Fluoride drops

Chewable tablets Rinse

Where is your water source from? SA _____ AH _____ OTHER _____

What is your child's attitude toward dentistry? _____

Is there any other information that you would like us to know about your child or have specific concerns about? _____

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