

Patient _____

DOB _____ Acct # _____

Dental History

Today's Date _____

Is this your child's first visit to a dentist? Yes No (Date of last exam) _____

Dentist's Name _____ Were x-rays taken? Yes No

Date and reason of last **medical** examination _____

Child's Physician _____ Street _____

City _____ State _____ Phone _____

Do you think your child will be a cooperative patient? Yes No

Does or did your child have problems which might affect oral health?

- clenching or grinding teeth mouth breathing pacifier finger or thumb habits
- lip sucking tooth abscess (gum boil) bad breath frequent sore throats
- cold sores (fever blisters) stained teeth toothaches bleeding gums
- traumatic injury to teeth _____ clicking/ popping / pain in the jaws
- other _____ Is your child presently nursing or drinking from a bottle? Yes No
- If no, when did they stop? _____ Usual contents in bottle? _____

Is fluoride taken in:

- water toothpaste pills vitamins liquid rinse gel not taken

Has your child ever had any of the following health problems?

- asthma / hay fever heart trouble or murmur sickle cell anemia breathing or lung problems
- blood disorders rheumatic fever diabetes deafness / hearing loss
- kidney / liver problems mental problems emotional problems convulsions / seizure / epilepsy
- growth problems hemophilia / other bleeding problems tumors / cancer / leukemia

Problems with:

- concentrating learning speech cooperating understanding

Does your child have any health problems? _____ Yes No

If yes, explain _____

Did your child have a history of health or mental problems at birth or during the initial years? Yes No

If yes, explain _____

Is your child taking any medications or drugs at this time? Yes No

Please list _____

Has your child ever had an unfavorable reaction/allergies to foods, drugs, (Penicillin, Codeine), or other medicines? Yes No

Please list _____

Does your child get car / motion sickness? Yes No

My signature below indicates that I understand and have answered all questions on the medical and dental health history to the best of my knowledge. I request and freely consent to the performance of any additional tests or procedures which are deemed necessary after a complete clinical examination. I have been informed that these procedures will be discussed with me prior to their taking place. I understand it is my responsibility to inform you of any health changes.

Signature (parent or guardian)

Date