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DENTAL HISTORY

Has your child been to the dentist before? _____

Date of last visit: _____ For what service? _____

Any unhappy dental experiences? Yes No
Any injuries to mouth or head? Yes No
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifer, etc? Yes No
Any unusual speech habits? Yes No
Any lost teeth? Yes No
Have missing teeth been replaced? Yes No
Orthodontic appliance worn now or ever before? Yes No
Does your child brush his/her teeth daily? Yes No
Do you assist your child with tooth brushing? Yes No
How often? _____
Is dental floss used? Yes No
How often? _____
Are disclosing tablets used? Yes No
Is fluoride taken in any form? Yes No
Do you desire complete dental service for the child? Yes No
Does child need to be premedicated before dental treatment? Yes No
Child's attitude to dentistry? _____

Please rate your child's dental health . Good Fair Poor Circle One

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In the event of an emergency, who should we contact?

Name _____ Relationship _____

Phone _____ Phone #2 _____

May we request release of your child's medical records for our reference? _____ I understand that the information that I have given is correct to the best of my knowledge, that it will be held in strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

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MEDICAL HISTORY

Child's Physician: _____

Address: _____

Phone? _____

Date of Last Visit? _____

Please rate your child's medical health _____ Good Fair Poor Circle One

Is child under the care of a physician now? Yes No

Is child taking any prescription drugs? Yes No

Is there excessive bleeding when cut? Yes No

Has child ever been hospitalized? Yes No

Has child ever had surgery? Yes No

Is your child allergic to penicillin or any drug? Yes No

Other allergies: food, pollen, animals, dust, etc: Yes No

Does child have good coordination? Yes No

Are there any emotional problems? Yes No

Has your child ever had any history of or difficulty with any of the following? Please circle

- Anemia Fainting Measles
Asthma Hearing Mononucleosis
Bladder Heart Mumps
Cerebral Palsy HIV+/AIDS Rheumatic Fever
Chicken Pox Hyperactive Thyroid
Chronic sinus Kidney Tuberculosis
Convulsions Liver Venereal Disease
Diabetes Malignancies Other
Epilepsy Mastoid

Does child have any other disease, condition or problem not listed above? _____ If so please explain

The parent or guardian who presents the child for treatment is responsible for payment at the time of service.



Signature of parent or guardian

Date

For Office Use: [] Medical History Verified by: _____