

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Nickname Date of Birth

PARENT'S/GUARDIAN'S NAME _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

COMMENTS

- 1. Is this your child's first visit to a dentist? YES NO
- 2. If not, how long since the last visit to the dentist? _____
- 3. Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
- 4. Does your child eat between meals? YES NO
- 5. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
- 6. When does your child brush his/her teeth?
 Upon arising After eating any food Right after meals Before going to bed
- 7. How does your child receive Fluoride?
 Community water level ___ ppm Well water level ___ ppm
 Fluoride drops or tablets Fluoride rinse or gel
- 8. Have any cavities been noted in the past? YES NO
- 9. Were any teeth (baby or permanent) removed by extraction? YES NO
Was it suggested that the space be maintained? YES NO
Was an appliance placed? YES NO
- 10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
If so describe _____
- 11. Has your child had any problem with dental treatment in the past? YES NO
- 12. Has anyone in the family, including parents, had orthodontics? YES NO
- 13. Has your child ever received a local anesthetic? YES NO
- 14. Has your child ever had occlusal sealants? YES NO
- 15. Does your child think there is anything wrong with his/her teeth? YES NO

Large empty rectangular box for handwritten comments.

MEDICAL HISTORY

- 1. Does your child have a health problem? YES NO
- 2. Is your child under care of physician? YES NO
If yes, since when and why? _____
- 3. Name of physician _____ Phone _____
- 4. Is your child receiving any medication? YES NO
What? _____
- 5. Is your child allergic to penicillin, antibiotics or other drugs? YES NO
- 6. Does your child have other allergies? YES NO
- 7. Has your child had any serious illness? YES NO
When _____ What _____
- 8. Has your child ever had surgery? YES NO
- 9. Does your child have a heart murmur? YES NO
- 10. Is surgery contemplated? YES NO
- 11. Does your child experience severe or prolonged bleeding? YES NO
- 12. Does your child have AIDS or has he/she tested HIV positive? YES NO
- 13. Has your child tested positive for hepatitis? YES NO
- 14. Is your child subject to nervous disorders? YES NO
 Fainting? Seizures? Dizziness? Behavioral/Learning problems?
- 15. Does your child have frequent headaches YES NO
- 16. Has your child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY