Name______________________________ **Age**__________

Today's Date______________

Dental History

Date of last dental visit______________ For what service?______________

Name of previous dentist______________ Phone number______________

Has your child had any difficulty with previous visits to the dentist?______________

Has your child complained of any dental problems?______________

If so, please explain:______________

Do you brush/floss your child's teeth or do they do it themselves?______________

How often? Brush______________ Floss______________

Is your child's water fluoridated?______ Does your child take fluoride supplements?____

Who prescribed the fluoride supplements for your child?______________

Has your child had any injuries to his/her mouth, teeth, or head that you are aware of?______________

If yes, please explain:______________

Does your child currently have or had in the past, any mouth habits? (Check all that apply) _______

_______Pacifier _______Thumb/finger sucking _______mouth breathing

______Sleeping with bottle/cup ______________

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Medical History

Child's Physician______________Phone #______________

Date of last physical examination______________ Is your child under the care of a Dr. now?_________ For what?______________

Is your child taking any medications (Over the counter or Prescription)______________

Medication______________ Reason______________

Medication______________ Reason______________

Does your child see any specialists?______________

Name of Physician______________ Phone #______________

Has your child ever been hospitalized?______________

Reason______________ Date of Hospitalization______________

Has your child ever had surgery?______________

For what?______________ Date of Surgery______________

Has your child had any history of or difficulty with any of the following?______________

____AIDS ____Cerebral Palsy ____Epilepsy ____Kidney Disease

____Asthma ____Anemia ____Chicken Pox ____Fainting Spells

____ Latex Allergy ____Sinus Problems ____Down Syndrome ____ADHD

____ Hearing Problems/Deafness ____Measles ____Bronchitis

____Bladder Problems ____Diabetes ____Heart Disease ____Tuberculosis

____Heart Murmur (Does your child require pre-medication prior to treatment?________

____Mononucleosis ____Hepatitis ____Mumps ____Cystic Fibrosis

____Cancer/Leukemia ____Autism ____Blindness ____Sleep Apnea

____Stomach problems (Acid Reflux Disease) ____Blood Transfusions______________

____Allergies (Seasonal/Other) If other, what?______________

____

**Is your child allergic to any medications?______________

Name of medication______________ Allergic reaction______________

______________ Allergic reaction______________

Is there anything else we need to know about your child? ______________

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