

PATIENT'S NAME _____
Last First Initial Date of Birth

PARENT'S NAME _____
Last First Initial

CIRCLE THE APPROPRIATE ANSWER

DENTAL HISTORY

- 1. Is this the child's first visit to a dentist?.....YES NO
- 2. If not, how long since the last visit to the dentist?_____
- 3. When was the last time the teeth were cleaned?_____
- 4. Were X-rays taken?.....YES NO
- 5. Does the child eat between meals?.....YES NO
- 6. Does the child eat sweets, such as candy, soda pop, chewing gum?.....YES NO
- 7. Does the child eat well-balanced meals?.....YES NO
- 8. Does the child brush teeth upon arising?.....YES NO
 - When going to bed?.....YES NO
 - Right after eating meals?.....YES NO
 - After eating any food?.....YES NO
- 9. Do you live in an area without fluoridated water?.....YES NO
- 10. Have teeth been treated with fluorides?.....YES NO
- 11. Have any cavities been noted in the past?.....YES NO
- 12. Were any teeth (baby or permanent) removed by extraction?.....YES NO
 - Was it suggested that the space be maintained?.....YES NO
 - Was appliance placed?.....YES NO
- 13. Have there been any injuries to teeth, such as falls, blows, chips, etc?.....YES NO
 - If so, describe _____
- 14. Has the child had any unfavorable dental experiences?.....YES NO
- 15. How many children in your family?_____
- 16. Has anyone in the family, including parents, had orthodontics?.....YES NO
- 17. Has child ever received a local anesthetic or any form of anesthetic?.....YES NO
- 18. Has child ever had occlusal sealants?.....YES NO

MEDICAL HISTORY

- 1. Is child in good health?.....YES NO
- 2. Is child under care of physician?.....YES NO
 - If yes, since when _____ Why _____
- 3. Name of physician _____
- 4. Is child receiving any medication?.....YES NO
- 5. Has the child had any serious illness?.....YES NO
- 6. Is the child allergic to penicillin, antibiotics, or other drugs?.....YES NO
- 7. Does the child have any other allergies?.....YES NO
- 8. Has child had surgery?.....YES NO
- 9. Is surgery contemplated?.....YES NO
- 10. Is child subject to profuse bleeding?.....YES NO
- 11. Is child subject to nervous disorders?.....YES NO
 - Fainting?.....YES NO
 - Dizziness?.....YES NO
- 12. Has child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

COMMENTS

PRESENT MEDICATIONS
ALLERGIES (DRUGS OR OTHER)
OTHER EXPLANATIONS

CHILD DENTAL MEDICAL HISTORY