Patient's Name____

Last Name First Name Middle Initial

Preferred Name ______________________________ Sex: F M Age_________ Birthdate ______________________

M/D/YY

School__________________________________ Grade______ Hobbies/Sports_____________________________________

Dental History

Former Dentist____ Address______________________________________ Phone _________________________

Date of last dental care____ Date of last x-rays____

What is the reason for your visit today? ____

What was done at your last dental visit? ____

Does/Is your Child:

❍Yes ❍No Brush? How Often? ______________________________

❍Yes ❍No Floss? How Often? ______________________________

❍Yes ❍No Experience pain or discomfort in the jaw joint (TMJ Pain)?

❍Yes ❍No Grind/Clench Teeth? If so, please circle answer

❍Yes ❍No Has the patient ever experienced a mouth or chin injury?

❍Yes ❍No Have speech problems?

❍Yes ❍No Use a pacifier, suck thumb/finger/lip, and/or bite lip? If so, please circle answer

❍Yes ❍No Bite or chew nails?

❍Yes ❍No Gag easily?

❍Yes ❍No Breastfed? Age Discontinued_______________________

❍Yes ❍No Bottlefed? Age Discontinued_______________________

❍Yes ❍No Require Antibiotics for dental work?

❍Yes ❍No Need dental work completed (referred from another dentist or you feel they do)

❍Yes ❍No Presently in dental pain? ____

❍Yes ❍No Have any other habits not listed above? If yes, please specify ______________________________

❍Yes ❍No Ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?
Explain: ____

Other information about the patient's dental health or previous treatment: _______________________________________

____

Medical History

Patient's Physician______________________________________ Phone___________________ Date of last visit ___________

Please check any conditions that may apply to your child & circle exact answer

❍AIDS/HIV Positive
❍Anemia
❍Asthma
❍Atopic (allergy prone)
❍Attention Deficit
❍Autism
❍Blood Disease
❍Cancer

❍Cerebral Palsy
❍Chicken Pox
❍Cough, persistent
❍Diabetes
❍Down Syndrome
❍Epilepsy/Seizures
❍Fainting
❍Food Allergies_____
____
____

❍Headaches
❍Hearing Impairment
❍Heart problems
❍Hemophilia/Abnormal bleeding
❍Kidney disease or malfunction
❍ Liver Disease
❍Respiratory disease
❍ Sensory Integration Disorder

❍ Sinus problems
❍ Skin rash
❍ Thyroid disease
❍ Tonsillitis
❍ Tuberculosis
❍ Other Describe:
____
____
____

❍Yes ❍No Current medications & dosages taken: ____

❍Yes ❍No Has the patient had any serious illnesses or operations? If yes, describe ______________________________
____

❍Yes ❍No Is the patient currently under physician care? If yes, describe _____________________________________
____

❍Yes ❍No Has the patient ever had a blood transfusion? If yes, approximate dates: _____________________________

❍Yes ❍No Allergies or adverse reactions to any medications (e.g. penicillin/sulfas)? ____________________________
____

❍Yes ❍No Allergies to any substances (e.g. latex) ____

❍Yes ❍No Has your child had any abnormal bleeding associated with previous extractions, surgery or trauma? If yes, please explain ____