

Child Dental & Medical History

Name _____ Date of Birth _____
Last First

Address _____
Street City Zip

Parents / Guardians Name _____

Phone Home _____ Work _____ Parent's E-Mail _____

In Case of Emergency, Please Contact _____ Phone _____

Whom we thank for this referral? _____ Name _____
Employer _____ Employer _____
Dental Insurance Primary Carrier Group # _____ ID# _____
Subscriber name _____ DOB _____
Secondary Carrier Group # _____ ID# _____
Subscriber name _____ DOB _____

1. Is this your child's first visit to the dentist? _____ YES NO
2. If not, how long since the last visit to the dentist? _____
3. Does your child eat between meals? _____ YES NO
4. Does your child eat sweets, such as candy, gum, soda, etc. _____ YES NO
5. How often does your child brush his/her teeth? _____
6. Does your child take a fluoride vitamin? _____ YES NO
7. Does your drinking water come from a well? _____ YES NO
8. If so, has your well been tested for fluoride content? _____ YES NO
9. Have any cavities been noted in the past? _____ YES NO
10. Were any teeth (baby or permanent) removed by extraction? _____ YES NO
11. Have there been any injuries to the teeth? (falls, blows, etc.) _____ YES NO
12. Has your child had any problems with dental treatment in the past? _____ YES NO
13. Has your child ever received local anesthetic? _____ YES NO
14. Has your child ever received nitrous oxide gas? _____ YES NO

1. Does your child have a health problem? _____ YES NO
2. Is your child under the care of a physician? _____ YES NO
3. Name of physician _____ Phone _____
4. Is your child receiving any medication? _____ YES NO
5. If so, what? _____
6. Does your child have any allergies? _____ YES NO
7. If so, to what? _____
8. Has your child had any serious illness? _____ YES NO
9. If so, what? _____
10. Does your child have a heart murmur? _____ 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. Has your child had a history of: (circle appropriate responses.) diabetes, heart trouble, asthma, seizures. _____

I certify that the above information is complete and accurate.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____
DOCTOR'S SIGNATURE _____ DATE _____