

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

### **Dental History**

What is the reason for this visit?  Checkup  Toothache  Orthodontic  Other \_\_\_\_\_

Is this the patient's first visit to the dentist? **Yes No** Date of last visit: \_\_\_\_\_

Previous dentist's name: \_\_\_\_\_

Purpose of child's last dental visit? \_\_\_\_\_

How can we help make this a positive visit for your child? \_\_\_\_\_

Was your child bottle fed? Yes No Breast fed? Yes No Until what age? \_\_\_\_\_

Does your child go to nap/bed with a bottle or sippy cup? Yes No

Does your child have any of the following oral habits?

Pacifier **Yes No**

Thumb/Finger Sucking **Yes No**

Nail Biting **Yes No**

Other: \_\_\_\_\_

Has your child ever had any injuries to teeth/mouth/head? Broken or chipped teeth? **Yes No**

If yes, please explain: \_\_\_\_\_

Does your child eat food or drink beverages, including juices, milk and soda five or more times a day? **Yes No**

Does your child brush his/her teeth daily? **Yes No** Floss teeth daily? **Yes No**

Does parent help with brushing/flossing? **Yes No**

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### **Medical History**

Child's Pediatrician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Is your child under care of physician now? Yes No

Medications your child is taking now: \_\_\_\_\_

**Allergies to any medications?** \_\_\_\_\_

Ever had surgery/hospitalization? When/why? \_\_\_\_\_

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**Please circle any condition your child currently has or has ever had:**

ADD	Cerebral Palsy	Liver Disease
AIDS/HIV	Diabetes	Lung Disorder
Allergy to Latex	Earaches	Mental Delays
Allergy to Food (detail below)	Epilepsy	Muscle Disorder
Allergies-other (detail below)	Gag Reflex-Severe	Physical Delays
Anemia	Hearing Impaired	Physical Handicap
Asthma	Heart Problems	Premature Birth_____ weeks
Autism	Hepatitis	Rheumatic Fever
Bladder Problems	Kidney Problems	Sinus Problems
Cancer	Learning Difficulty	Speech Impaired/Delayed
		Tuberculosis

Other: \_\_\_\_\_

If needed, detail medical conditions: \_\_\_\_\_

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The above medical, dental and medication history is complete and accurate to the best of my knowledge. I will notify you of ANY changes to the patient's health history prior to ANY appointment.

Signed (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

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