PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Nickname Date of Birth

PARENT'S/GUARDIAN'S NAME

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ..... YES NO
4. Does your child eat between meals? ..... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
6. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
7. How does your child receive Fluoride?
   ☐ Community water level ___ ppm ☐ Well water level ___ ppm
   ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
8. Have any cavities been noted in the past? ..... YES NO
9. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
   Was it suggested that the space be maintained? ..... YES NO
   Was an appliance placed? ..... YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... YES NO
    If so describe _____
11. Has your child had any problem with dental treatment in the past? ..... YES NO
12. Has anyone in the family, including parents, had orthodontics? ..... YES NO
13. Has your child ever received a local anesthetic? ..... YES NO
14. Has your child ever had occlusal sealants? ..... YES NO
15. Does your child think there is anything wrong with his/her teeth? ..... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? ..... YES NO
2. Is your child under care of physician? ..... YES NO
   If yes, since when and why? _____
3. Name of physician Phone
   _____
4. Is your child receiving any medication? ..... YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? ..... YES NO
6. Does your child have other allergies? ..... YES NO
7. Has your child had any serious illness? ..... YES NO
   When _____ What _____
8. Has your child ever had surgery? ..... YES NO
9. Does your child have a heart murmur? ..... YES NO
10. Is surgery contemplated? ..... YES NO
11. Does your child experience severe or prolongated 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. Is your child subject to nervous disorders? ..... YES NO
    ☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?
15. Does your child have frequent headaches ..... YES NO
16. Has your child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALER

Form No. 131CDM

CHILD DENTAL MEDICAL HISTORY