GENERAL

Child's Name: ____

Describe the primary concern with your child's teeth:

____

Has your child had any unfavorable reactions to past dental treatment? If so, please explain:

____

What things does your child enjoy?:____________________________

DENTAL

Does/Is your Child:

o Yes o No Take Fluoride Supplements
o Yes o No Use a pacifier, suck thumb/finger/lip, bite lip If so, please circle answer
o Yes o No Bite or chew nails
o Yes o No Grind teeth/clench Jaws/have TMJ pain? If so, please circle answer
o Yes o No Gag easily
o Yes o No Brush daily If so, how often?___ Floss daily? o Yes o No If so, how often?____
o Yes o No Breastfed Age discontinued____
o Yes o No Bottlefed Age discontinued____
o Yes o No Require Antibiotics for dental work?
o Yes o No Need dental work completed (referred from another dentist or you feel they do)
o Yes o No Presently in dental pain?
o Yes o No Have any extra, missing, or extracted teeth? If so, please circle answer
o Yes o No Have a history/present today with trauma to the head, face, or teeth? which one?
o Yes o No Have any other habits not listed above? If yes please specify________________

MEDICAL

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

O Asthma/Respiratory problems
O Autism/ADD/ADHD
O Brain Injury
O Bleeding disorder/Delay/Anemia
O Cancer
O Cerebral Palsy/CNS problem
O Congenital Heart Defect/Problem
O Diabetes
O Drug/Alcohol Abuse
O Epilepsy/Seizures
O Endocrine
O Gastrointestinal/Kidney
O Heart Murmur
O Hepatitis/Liver/Infectious Dis
O Herpes/Fever Blisters
O Immunizations up to date
O Lung Problems
O Mental Disorder
O Rheumatic Fever
O Speech Delay
O Transfusion
O Tuberculosis
O Vision Disorder
O My child is healthy
O Developmental Delay
O Other:____

If you said yes to any of the above, please explain:_______________________________________

Current medications & dosages taken:____

Allergies or adverse reactions to any medications (e.g. penicillin/sulfas)______________________

Allergies to any substances (e.g. latex)____

Previous hospitalizations, surgeries, or serious illnesses, and date__________________________

Has your child had any abnormal bleeding associated with previous extractions, surgery, or trauma? (If yes, please explain)____

Date of last dental visit_____________________ Previous Dentist___________________________

Child's Pediatrician:________________________ Phone Number ___________________________

Is there anything else you would like us to be aware of regarding your child?__________________

Authorization and Release To the best of my knowledge, the question on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and /or other health practitioners as necessary. May we request release of your child's medical and dental records?_________________

With your verbal permission, you agree to release your child's records to another doctor at their/your request

Signature of Parent/Guardian **X**__________________________________ Date:____________