



## 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:

- Yes  No Take Fluoride Supplements
- Yes  No Use a pacifier, suck thumb/finger/lip, bite lip If so, please circle answer
- Yes  No Bite or chew nails
- Yes  No Grind teeth/clench Jaws/have TMJ pain? If so, please circle answer
- Yes  No Gag easily
- Yes  No Brush daily If so, how often?\_\_\_\_ Floss daily?  Yes  No If so, how often?\_\_\_\_
- 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 extra, missing, or extracted teeth? If so, please circle answer
- Yes  No Have a history/present today with trauma to the head, face, or teeth? which one?
- Yes  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

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

