Child Health/Dental History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (P.O. BOX OR MAILING ADDRESS / CITY / STATE / ZIP)		
Phone (HOME / WORK)	Patient's Sex ❑ F ❑ M	

Y N Is this your child's first dental visit? If not, when was the last visit & by whom?

_____

When does your child brush his/her teeth? ❑ Morning ❑ Between meals ❑ Bedtime

Y N Do you or someone supervise the brushing?

Y N Does your child floss?

Y N Has your child had any ortho treatment? If so, when? ____ / ____ / ____

Y N Has your child had any injuries to the mouth, head, or teeth? Please explain

_____

What type of water do you use? ❑ City ❑ Well ❑ Bottled

Does your child consume any of the following on a daily basis :(check all that apply)

❑ Soda ❑ Juice ❑ Sport drinks ❑ Chips ❑ Crackers/Dry Cereal ❑ Candy/Gum

Y N Does your child suck a thumb or finger, use a pacifier, chew on fingernails or other materials?

Are there any specific dental concerns you would like us to address? _____

_____

Y N Does your child need to be pre-medicated prior to dental treatment?

If so, what drug? _____

Y N Is your child currently under the care of a physician?

If yes, please explain: _____

Y N Are your child's vaccinations current?

Y N Does your child take medication? Please list with dosage and frequency: _____

_____

Y N Does your child have any allergies to medications, food, latex, milk, or other materials?

Please list: _____

Y N Has your child ever been admitted to a hospital, had surgery, a serious illness or injury?

Please list the date and reason: _____

_____

Does your child have a history of any of the following (circle all that apply):

Y N Heart murmur or any heart disease

Y N Respiratory problems (asthma, reactive airway disease, tuberculosis, etc.)

Y N Neurological disorders (epilepsy, seizures, cerebral palsy, convulsions, shunts, etc.)

Y N Sight, hearing or speech problems

Y N Bleeding disorders, anemia, transfusions, HIV, or immuno-compromised conditions

Y N Diabetes, lupus, arthritis, or auto-immune diseases

Y N Premature birth (by how many weeks) _____

Y N Liver disease, hepatitis, or jaundice

Y N Kidney, stomach or gastrointestinal disorders

Y N Skin, bone, or muscle disorders

Y N Leukemia, cancer, or tumors

Is there anything else we should know while treating your child? _____

_____

X_____ _____ _____

Your Signature Date Your relationship to child