



PATIENT'S NAME \_\_\_\_\_  
Last First Initial Date of Birth

PARENT'S NAME \_\_\_\_\_  
Last First Initial

**DENTAL HISTORY** (Please circle appropriate answer)

- YES NO Is this the child's first dental visit? \_\_\_\_\_  
If not, when was the last appointment? \_\_\_\_\_  
When were the teeth last cleaned? \_\_\_\_\_  
How many time a day does the child brush? \_\_\_\_\_
- YES NO Do you live in an area without fluoridated water?
- YES NO Have the teeth been treated with fluorides?
- YES NO Were any teeth removed by extraction?
- YES NO Was it suggested that the space be maintained?
- YES NO Was appliance placed?
- YES NO Has your child had any unfavorable dental experiences?
- YES NO Has anyone in the family, including parents, had orthodontics?
- YES NO Has a local anesthetic ever been used?
- YES NO Has the child ever had occlusal sealants?
- Describe any previous dental injuries \_\_\_\_\_  
\_\_\_\_\_

**COMMENTS**

**MEDICAL HISTORY**

Name of Physician \_\_\_\_\_

Please (X) if your child has, or had, any of the following

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Heart Trouble    | <input type="checkbox"/> Ear Infection      |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Toothache          |
| <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Fainting           |
| <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Dizziness          |

- |  |
|--|
| <input type="checkbox"/> Nervous Disorders     |
| <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Learning disabilities |

Is your child allergic to:

- Penicillin       Other Medications or Substances  
 Antibiotics      List: \_\_\_\_\_

List any medications your child is now taking \_\_\_\_\_  
\_\_\_\_\_

Please explain any serious illness or surgery \_\_\_\_\_  
\_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S /GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**CHILD DENTAL / MEDICAL HISTORY**