Your answers to these questions are of great value in aiding us to a better understanding of your child.

TODAY'S DATE ___________________________

CHILD'S FULL NAME: FIRST MIDDLE LAST (NICKNAME)		SEX: ❒ MALE ❒ FEMALE	AGE	DATE OF BIRTH
PLACE OF BIRTH	SCHOOL	GRADE	REASON FOR THIS VISIT	
REFERRED TO THIS OFFICE BY:				

Medical History

CHILD'S PHYSICIAN	CITY	PHONE ( )	DATE LAST SAW PHYSICIAN (MO/YEAR)

1. Was your child born of a normal 9 mos. term pregnancy? ❒ YES ❒ NO
   If premature, how many months? _______________
2. Is your child presently under the care of a physician? ❒ YES ❒ NO
   If yes, why? ____
3. Has your child ever been hospitalized? ❒ YES ❒ NO
   If yes, why? ____
4. Is your child taking any medications now? ❒ YES ❒ NO
   If yes, why? ____
5. Is your child handicapped in any way? ❒ YES ❒ NO
   If yes, how? ____
6. Is your child allergic to any medications, foods, or latex? ❒ YES ❒ NO
   If yes, what? ____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS?

❒ Heart Trouble or Murmur
❒ Rheumatic Fever
❒ Brain Injury
❒ Diabetes
❒ Asthma
❒ Seizures
❒ Epilepsy
❒ Cancer
❒ Hepatitis
❒ Bleeding Problems
❒ Anemia
❒ Blood Transfusion
❒ Bladder/Kidney Disorders
❒ Ear Infections
❒ Cerebral Palsy
❒ MentaL Retardation
❒ Speech/Learning Disabilities
❒ Eye Problems
❒ Skin Disorders
❒ Emotional Disturbances
❒ HIV Positive/AIDS

Adolescent Women: ❒ Pregnant (or might be)
❒ Taking birth control pills
❒ Ever taken diet pills/weight loss medication

Other conditions? please explain ____
____
____

Dental History

CHILD'S FIRST DENTAL VISIT? ❒ YES ❒ NO	PREVIOUS DENTIST	CITY	DATE OF LAST VISIT
ANY INJURIES TO TEETH OR JAWS? (Falls, Blows, Chips, etc.) ❒ YES ❒ NO		EXPLAIN NATURE OF INJURY & DATE	
HISTORY OF: ❒ THUMB SUCKING ❒ LIP SUCKING ❒ TEETH GRINDING ❒ PACIFIER ❒ TONGUE THRUSTING		FOR PATIENTS UNDER 5 YEARS OLD: STILL USING A BOTTLE? ❒ YES ❒ NO	
ANY UNFAVORABLE REACTIONS TO PREVIOUS MEDICAL OR DENTAL CARE? ❒ YES ❒ NO		IF YES, PLEASE EXPLAIN	
HOW DO YOU THINK YOUR CHILD WILL REACT TOWARD THE DENTIST?		NAME OF FAMILY DENTIST CITY	
HOW OFTEN DOES YOUR CHILD BRUSH?	IS BRUSHING ASSISTED BY AN ADULT? ❒ YES ❒ NO	DO THE GUMS BLEED WHEN TEETH ARE BRUSHED? ❒ YES ❒ NO	
IS DENTAL FLOSS USED? ❒ YES ❒ NO	DOES YOUR CHILD RECEIVE: ❒ FLUORIDE IN VITAMINS ❒ FLUORIDE TABLETS/DROPS ❒ FLUORIDATED WATER ❒ NONE		

The below signature indicates your verification that the above information is correct.

Parent/Guardian Signature: ____________________________ **Date** ______________

Doctor's Signature ____________________________ **Date** ______________