Child Dental History

What would you like us to do today? ________________________ Is child in dental discomfort today? ______

Former Dentist _______________________ Address _________________________ Phone _______________

Date of last dental visit? ______________________ What was done at that time? ________________________

When was last cleaning appointment? ___________________ Date of last x-rays? _______________________

Check (√) if you have had problems with any of the following:

☐ Bad Breath	☐ Food collection between teeth	☐ Thumb sucking	☐ Snoring	
☐ Bleeding Gums	☐ Grinding or clenching teeth	Sensitivity to: ☐ Hot	☐ Cold ☐ Sweets	☐ Biting
☐ Gingivitis	☐ Clicking or popping jaw	Sores in: ☐ Mouth	☐ Lips ☐ Tongue	

How often does child brush? ______________ Floss? ____________ Does an adult help? __________________

Do you have any concerns about your child's teeth? ____

Has your child been cooperative during past medical or dental appointment? ☐ Yes ☐ No If No, please explain ____

Other information you would like us to know about child's dental health or previous treatment _____________

____

Child Medical History

Physician's name ____ Phone __________________________

Date of last visit _____________________ Has child had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe ____

Is child currently under a physicians care? ☐ Yes ☐ No If yes, describe ________________________________

Check (√) if you have had problems with any of the following:

☐ AIDS/HIV Positive	☐ Epilepsy	☐ Hives or Rash	☐ Spinal Bifida
☐ Anemia	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Stomach or Intestinal Diseases
☐ Arthritis	☐ Fainting spells	☐ Kidney Problems	
☐ Asthma	☐ Frequent Cough	☐ Leukemia	☐ Swelling
☐ Autism	☐ Frequent Headaches	☐ Liver Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Hay Fever	☐ Lung Disease	☐ Tonsillitis
☐ Breathing Problem	☐ Heart Murmur	☐ Rheumatic Fever	☐ Tuberculosis
☐ Bruises Easily	☐ Heart Disease	☐ Scarlet Fever	☐ Tumors or Growths
☐ Heart ____________	☐ Hemophilia	☐ Shingles	☐ Ulcers
☐ Convulsions	☐ Hepatitis A	☐ Sickle Cell Anemia	☐ Yellow Jaundice
☐ Diabetes	☐ Hepatitis B or C	☐ Sinus Trouble	

Has child every had any serious disease not listed above**?** ☐ Yes ☐ No If yes, please explain: __________

____

List medications child is taking, if any:
____
____

List drug allergies, if any
____
____

I have completed this form on behalf of my child and to the best of my knowledge all information in listed and correct.

Completed by : __________________________ __________________________ ______________ _____________

Signature Print Name Relationship Date