

Child Dental/Medical History

Child's Name _____ Date _____

Is this your child's first visit to a dentist? Yes No
 If not, how long since the last visit? _____

Is your child in pain? Yes No
 Were any x-rays or radiographs taken at the last visit? Yes No

When does your child brush their teeth?
 Upon rising After eating any meal Before bed

Has your child ever had sealants? Yes No
 How does your child receive fluoride?
 Community water Well water Fluoride drops/tablets/rinse

Was your child breastfed, bottle fed, or both? (please circle your response)

Does your child grind or clench their teeth? Yes No
 Does your child bite their nails? Yes No
 Does your child currently use a bottle or pacifier? Yes No

Are your child's immunizations up to date? Yes No
 Is your child under the care of a physician? Yes No
 If yes, since when and why?
 Name of physician: _____

Is your child receiving any medication? Yes No
 What? _____
 Is your child allergic to any medications? Yes No
 If so, what? _____
 Does your child have any allergies to latex or metals? Yes No
 Has your child ever had surgery? Yes No
 For what and when? _____

Has your child ever had a history of any of the following? **Circle all that apply**

Diabetes	Anemia	Cancer	Hearing loss/ impairment	Ear infections	Congenital birth defects
Cleft lip or palate	Speech impairments/de lay	Heart defect	Kidney infections	Mental retardation	Rheumatic fever
Chronic sinusitis	Prolonged bleeding/easy bruising	Heart murmur	Coagulation disorder	Sickle cell anemia or trait	Cystic fibrosis
Epilepsy/ seizure disorder	Down syndrome	Blood transfusion	Autism or spectrum disorder	Cerebral palsy	Liver problems
HIV/AIDS	Hepatitis	Heart repair	Developmental delay	Asthma	ADHD

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature _____

Date _____