Patient _____ Date of Birth _____

CONFIDENTIAL PATIENT MEDICAL HISTORY

Physician's Name _____ Phone Number _____ Date of Last Visit _____

Has your child ever been under the extended care of a physician or had any medical/dental surgeries? Yes □ No □

Has your child ever broken a bone? Yes □ No □

If yes, please explain: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

□ Heart Conditions (murmur, etc)	□ HIV Positive	□ Frequent Headaches
□ Excessive Bleeding	□ Tuberculosis	□ Kidney Infections
□ Diabetes	□ Asthma/Respiratory Problems	□ Cerebral Palsy
□ Rheumatic Fever	□ Epilepsy	□ Eyesight Problems
□ Liver Problems	□ Birth Defects	□ Speech Impairments
□ Cancer	□ Infections	□ Tubes in Ears
□ Hearing Loss	□ Hepatitis	

Is your child currently on any medications? Yes □ No □ If Yes: _____

Does your child have any allergies? (i.e. medications, food, latex or dyes) Yes □ No □ If Yes: _____

Is your child subject to any nervous disorders? Yes □ No □ If Yes: _____

CONFIDENTIAL PATIENT DENTAL HISTORY

Last Dentist's Name _____ Phone Number _____ Last Visit _____

Were any x-rays taken at your last dental visit? Yes □ No □

Has your child had any problems with dental exams or treatment in the past? Yes □ No □

Have any cavities been noted in the past? Yes □ No □

Does your child eat between meals? Yes □ No □

Does your child eat sweets? (candy, soda pop, chewing gum, fruit snacks, etc) Yes □ No □

Has any family members ever needed orthodontics in the past? Yes □ No □

Has your child ever received local anesthetic? Yes □ No □

Has your child ever had occlusal sealants placed? Yes □ No □

Has parent or caregiver been diagnosed with tooth decay in the past 2 years? Yes □ No □

Has your child had any baby or permanent teeth extracted in the past? Yes □ No □

If yes, was it suggested that the space be maintained? Yes □ No □

Was an appliance placed? Yes □ No □

Has your child experienced any trauma to the teeth? (falls, blows, chips, etc) Yes □ No □

If yes, please explain: _____

How often does your child floss? _____

When does your child brush their teeth?

□ Upon rising in the morning □ After eating any food □ After meals □ Before going to bed

How does your child currently receive fluoride?

□ Community Water, ppm ___ □ Well Water, ppm ___ □ Drops or Tablets □ Rinse or Gels

Please describe your child's diet (regular/favorite foods): _____

**To help connect with your child please tell us about his/her interests (favorite sports, hobbies, TV Shows, movies, etc)

_____

_____

Thank you for taking the time to fill this form out!

I certify that the above information is complete and accurate.

Parent/Guardian Signature: _____ Date: _____