PATIENT NUMBER

Patient's Name _____
Last First Inital Nickname Date of Birth

Parent's Guardian's Name _____

DENTAL HISTORY - CHECK THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist ? ..... YES NO
2. If not, how long since the last visit to the dentist ? _____
3. Does your child eat between meals? ..... YES NO
4. Does your child eat sweets,such as candy, soda, chewing gum? ..... YES NO
5. When does your child brush his/her teeth?
   Upon waking After eatting any food Right after meals Before going to bed
6. How does your child receive Fluoride?
   Community water level ____ ppm Well water level ____ ppm
   Fluoride drops or tablets Fluoride rinse or gel
7. Have there been any injuries to teeth, such as falls, blows, chips,ect ? ..... YES NO
   If so, describe _____
8. Has your child had any problem with dental treatment in the past? ..... YES NO
9. Has your child ever received a local anestheic? ..... YES NO
10. Has your child ever had occlusal sealants? ..... YES NO
11. Does your child think there is anything wrong with his/her teeth ? ..... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? ..... YES NO
2. Is your child under care of physician? ..... YES NO
   If yes, since when and why? _____
3. Name of physician _____ Phone _____
4. Is your child receiving any medication? ..... YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? ..... YES NO
6. Is your child allergic to or sensitive to any metals or latex ? ..... YES NO
7. Does your child have other allergies? ..... YES NO
8. Has your child had any serious illness ? ..... YES NO
   When _____ What _____
9. Has your child ever had surgery? ..... YES NO
10. Does your child have a heart murmur? ..... YES NO
11. Does your child experience severe or prolongated bleeding ? ..... YES NO
12. Does your child have AIDS or has he/she tested HIV positive? ..... YES NO
13. Has your child tested positive for hepatitis? ..... YES NO
14. Is your child subject to nervous disorders? ..... YES NO
    Fainting? Seizures? Dizziness? Behavioral/Learning problems?
15. Does your child have frequent headaches? ..... YES NO
16. Do you want to tell the dentist any information about your child ? ..... YES NO

_____

_____

17. Has your child had history of: ( Circle appropriate responses ) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight probleams, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

# CHILD DENTAL MEDICAL HISTORY