CHART NO. _____

Are you under 18?

We are excited to help your child maintain their youthful smile! :-) And, we look forward to a lasting relationship with them that extends into adulthood. The information provided is very important to their overall health. If you have any questions, please don't hesitate to ask.

Personal Information

Name of Minor _____ DOB / / Age Sex
First *Middle* *Last*
Is dental and/or medical insurance of minor same as parent/guardian? _____ SSN – –

Name of Parent/Guardian _____ SSN – –
First *Middle* *Last*

Dental History

1. Is this the child's first visit to a dentist? ___/___/___
   a. If not, how long since the last visit to he dentist? _____
2. When was the last time the teeth were cleaned? ___/___/___
3. Does child eat between meals? _____
4. Does child eat sweets (candy, soda pop, chewing gum)? _____
5. Does child eat well balanced meals? _____
6. Does child brush teeth upon rising? _____
   a. When going to bed? _____
   b. Right after eating meals? _____
   c. After eating any food? _____
7. Do you live in area without fluoridated water? _____
8. Have teeth been treated with fluoride? _____
9. Have any cavities been noted in the past? _____
10. Were any teeth (baby or permanent) removed by extraction? _____
    a. Was it suggested that the space be maintained? _____
    b. Was an appliance placed? _____
11. Have there been any injuries to teeth (falls, blows, chips, etc.)? _____
    a. If so, describe _____
12. Has child had any unfavorable dental experiences? _____
13. How many children in your family? _____
14. Has anyone in the family, including parents, had orthodontics? _____
15. Has child ever received a local anesthetic or any form of anesthetic? _____
16. Has child ever had occlusal sealants? _____

Medical History

1. Is child in good health? _____
2. Is child under care of physician? _____
   a. If yes, since when?___/___/_____Why?_____
3. Name of physician?_____Location?_____
4. Is child receiving any medication? _____
   a. If yes, since when?___/___/_____Why?_____
5. Has child had any serious illness? _____
   a. If yes, when?___/___/_____Why?_____
6. Is the child allergic to penicillin, antibiotics, other drugs? _____
7. Does the child have any other allergies? _____
8. Has child had surgery? _____
9. Is surgery planned? _____
10. Is child subject to excessive bleeding? _____
    a. Fainting? _____
    b. Dizziness? _____
11. Has child had history of: (circle appropriate responses)?
    _____ diabetes, heart trouble asthma, kidney infection, rheumatic fever, toothache, ear infection

Parent/Guardian Signature X _____ **Today's Date** / /