PATIENT'S NAME ______________________________

Last | First | Initial | Date of Birth

PARENT'S NAME ______________________________

Last | First | Initial

CIRCLE THE APPROPRIATE ANSWER

COMMENTS (Include date, details, initials)

DENTAL HISTORY

1. Is this the child's first visit to a dentist? .... YES NO
2. If not, how long since the last visit to the dentist? __________
3. When was the last time the teeth were cleaned? __________
4. Does child eat between meals? .... YES NO
5. Does child eat sweets (candy, soda pop, chewing gum)? .... YES NO
6. Does child eat well balanced meals? .... YES NO
7. Does child brush teeth upon arising? .... YES NO
   When going to bed? .... YES NO
   Right after eating meals? .... YES NO
   After eating any food? .... YES NO
8. Do you live in an area without flouridated water? .... YES NO
9. Have teeth been treated with flourides? .... YES NO
10. Have any cavities been noted in the past? .... YES NO
11. Were any teeth (baby or permanent) removed by extraction? .... YES NO
    Was it suggested that the space be maintained? .... YES NO
    Was an appliance placed? .... YES NO
12. Have there been any injuries to teeth (falls, blows, chips, etc.)? .... YES NO
    If so, describe. __________
13. Has child had any unfavorable dental experiences? .... YES NO
14. How many children in your family? .... YES NO
15. Has anyone in the family, including parents, had orthodontics? .... YES NO
16. Has child ever received a local anesthetic or any form of anesthetic? .... YES NO
17. Has child ever had occlusal sealants? .... YES NO

DENTAL HISTORY

1. Is child in good health? .... YES NO
2. Is child under care of physician? .... YES NO
   If yes, since when? __________ Why? __________
3. Name of physician. __________
4. Is child receiving any medication? .... YES NO
   When? __________ Why? __________
5. Has the child had any serious illness? .... YES NO
   When? __________ Why? __________
6. Is the child allergic to penicillin, antibiotics or other drugs? .... YES NO
7. Does the child have any other allergies? .... YES NO
8. Has child had surgery? .... YES NO
9. Is surgery planned? .... YES NO
10. Is child subject to excessive bleeding? .... YES NO
    Fainting? .... YES NO
    Dizziness? .... YES NO
11. Has child had history of: (circle appropriate responses) diabetes, heart trouble
    asthma, kidney infection, rheumatic fever, toothache, ear infection.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S SIGNATURE __________________________ DATE __________

DENTIST'S SIGNATURE __________________________ DATE __________

CHILD DENTAL MEDICAL HISTORY