Child's Name:_____
Parent's Name:_____
Birthdate: _____

What is the primary reason for today's visit?

_____

Your child's current dental health:
good__ fair___poor___
Has the child experienced problems with previous dental work? Yes__ No__ If yes, please explain:

_____
_____

Was pregnancy: Full-term? ____

Premature? ____ How many weeks early? _____

Did he or she stay in hospital after birth? Yes__No__If yes, please explain: _____

At what age did your child get his/her first tooth? _____

Are your child's teeth brushed daily? Yes__No__
Flossed daily? Yes___ No___
Who is helping child brush? _____
Does your child experience any sensitivity to hot or cold? Yes___ No___
Have there been any injures to the head, neck, teeth or chin?

_____
Does your child have a finger or thumb sucking habit? Yes___No___ Pacifier habit? Yes__ No__
Does your child have any speech problems?
Yes___ No___ If yes please explain:

_____
Does your child have any birth defects? Yes__No__
If yes please explain:

_____
_____

Does your child have frequent colds, sore throats, ear infections, or tonsillitis? Yes___No___
If yes which condition(s)? _____
Have adenoids or tonsils been removed? Yes__No__
Has your child been informed of any missing or extra teeth? Yes____No____
Has your child ever had pain or tenderness in the jaw joint (TMJ/TMD)? Yes____ No____
Child's Physician: _____
Phone Number : _____
Date of Last Visit:_____
Is the child under the care of a Specialist? Yes___No___
Please list all medications your child is currently taking:

_____
_____
Please list all medications that cause your child an allergic reaction:

_____
_____
_____

Please discuss any medical problems the child has experienced or experiences:

_____
_____

Has your child experienced the following medical problems?

Y N Abnormal bleeding	**Y N** Hemophilia
Y N Anemia	**Y N** Hepatitis
Y N Allergies	**Y N** Hyper/Hypotension
Y N Hospital stays/Surgeries	**Y N** Hives
Y N Asthma	**Y N** HIV+
Y N Asperger Syndrome	**Y N** Kidney Trouble
Y N Autism	**Y N** Learning Disability
Y N Cancer	**Y N** Liver Disease
Y N Diabetes	**Y N** Mononucleosis
Y N Emotional Problems	**Y N** Rheumatic Fever
Y N Epilepsy, Seizures	**Y N** Scarlet Fever
Y N Heart Defect/ Murmur	**Y N** Sickle Cell
Y N Handicap/Disability	**Y N** Skin Rash
Y N Hearing Impairment	**Y N** Tuberculosis

If you answered yes to any of these please explain:

_____
_____

Is there anything you would like to discuss with the Doctor in private? Yes___No__ If yes, please explain:

_____
_____

Has your child been vaccinated? Y__ N__
What does your child drink between meals?

_____
What does your child snack on between meals?

_____

Has puberty begun? Yes__ No__ (If yes please continue to next question) Is patient taking birth control? Yes__ No__
Is patient pregnant? (x-ray exposure to a pregnant female can be hazardous to the unborn child) Unsure____ Yes___ No___

I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date

FOR OFFICE USE ONLY:

I verbally reviewed the medical/dental information given with the parent/guardian and parent named herein:

_____
Doctors signature Date