PATIENT HISTORY DATE _____

Child's Name: _____ Birth Date: _____ Age: _____ Gender: M / F

Home Address: _____ City: _____ State: _____ Zip: _____

Name and Age of Siblings _____

Interests or hobbies _____

How did you hear about us? _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mother's Name: _____
Address: _____
Home Phone: _____
Cell Phone: _____
Occupation: _____
Employer: _____
Business Phone: _____
Email Address: _____

Father's Name: _____
Address: _____
Home Phone: _____
Cell Phone: _____
Occupation: _____
Employer: _____
Business Phone: _____
Email Address: _____

MEDICAL HISTORY

Name and phone number of physician: _____

Date of your child's last medical exam: _____

Findings? _____

Does your child have any illness now? _____

Were there any problems with the birth or pregnancy? Yes No Has child ever been hospitalized? Yes No

If so, when and for what reason: _____

Are there any psychological or emotional problems you would like to bring to our attention? Yes No

Has child had any history of: (circle those that apply)

Accidents or Severe Infections
ADD/ADHD
AIDS or HIV+
Anemia or Blood Disorders
Asthma
Autism
Bacterial/ Viral Infection
Behavioral Problems
Bleeding Problems
Blood Transfusions
Blood Disease
Breathing Problems
Cerebral Palsy
Congenital Birth Defects
Congenital Heart Disease
Convulsion, Seizures, Epilepsy
Diabetes
Excessive Bleeding
Headaches (recurrent)
Heart Murmur
Hepatitis
Kidney or Bladder Problems
Liver Problems, Jaundice,
Lung Disease
Malignancies
Rheumatic Fever
Speech, Learning or Hearing Disorder
Temporal Mandibular Joint Problems
Tuberculosis
Vision Problem
Other, if so explain:

Is your child taking any medication at this time? …….. Yes No

Drug	Dose	Frequency	Reason

Has your child shown any allergies or unusual reactions?
a) Medications or drugs _____
b) Foods _____
c) Other _____
PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION THE DENTIST SHOULD BE AWARE OF OR HAS NOT BEEN COVERED ABOVE_____

_____

DENTAL HISTORY

Why did you make this appointment_____

Is this your child's first visit to a dentist? Yes No If not, how long since the last dental visit? _____

Child's previous dentist: Name _____Phone Number: _____

Approximate date of last dental "x-rays" _____Is former doctor transferring records: ☐ Yes ☐ No

Has your child ever had any unpleasant dental experiences? If so, explain _____

_____

Is there now or has there ever been any of the following? (Please circle)

Cavities	Toothache	Pain	Broken Tooth
Extracted Teeth	Straightened Teeth	Gum Infection	Mouth Injuries

Does child have a history of: (Please Circle)

Thumb Sucking	Finger Sucking	Lip Sucking	Teeth Grinding
Nail Biting	Pacifier Use	Prolonged use of bottle and/or breast feeding	

Does your child brush his/her own teeth? ☐ Yes ☐ No How frequently and when?_____

Do you brush your child's teeth? ☐ Yes ☐ No How frequently and when? _____

Do you or your child use dental floss in cleaning your child's teeth? ☐ Yes ☐ No
How frequently and when? _____

Has your child had fluoride in any of the following form?

Fluoride tablets or in multiple vitamins	☐ Don't Know	☐ Yes	☐ No
Drinking water (community fluoridation)	☐ Don't Know	☐ Yes	☐ No

Topical application on teeth (please circle) Dentist applied, Home rinse, Home brush-on gel or School rinse
Toothpaste brand _____
Have your child's teeth ever been injured? ☐ Yes ☐ No When?_____

Which teeth?_____Cause?_____

Were the teeth treated?_____If so, describe treatment_____

Does your child tend to complain of clicking, popping or crunching noises in his/her ears while chewing? ☐ Yes ☐ No

INFORMED CONSENT

The permission of the parent or guardian is necessary for dental treatment of a minor.

I give the doctor permission to use such measures as deemed necessary in his professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reaction to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Signature_____ Relationship to Child_____ Date_____

Reviewed by _____ Date _____