PATIENT HISTORY Date:_____

Child's Name:_____Birth Date:_____Age:_____ Gender: M / F

Home Address:_____City:_____State:_____Zip:_____

Name/Age of Siblings_____

Interests or hobbies_____

How did you hear about us?_____

Parent/Guardian 1:	Parent/Guardian 2:
Relationship to patient:	Relationship to patient:
Address:	Address:
Cell #:	Cell #:
Occupation:	Occupation:
Employer:	Employer:
Email Address:	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	Cerebral Palsy	Lung Disease
ADD/ADHD	Congenital Birth Defects	Malignancies
AIDS or HIV+	Congenital Heart Disease	Rheumatic Fever
Anemia or Blood Disorders	Convulsion, Seizures, Epilepsy	Speech, Learning or Hearing Disorder
Asthma	Diabetes	Temporal Mandibular Joint Problems
Autism	Excessive Bleeding	Tuberculosis
Bacterial/Viral Infection	Headaches (recurrent)	Vision Problem
Behavioral Problems	Heart Murmur	Other, if so explain:
Bleeding Problems	Hepatitis	
Blood Transfusions	Kidney or Bladder Problems	
Blood Disease	Liver Problems, Jaundice	
Breathing Problems		

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 when 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 If so, when? _____

Which teeth? _____ Cause? _____

Were the teeth treated? _____ If so, describe treatment _____

Does your child 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 _____