DENTAL HISTORY:

Why is your child here today? _____

Is there a specific problem? _____

Is your child currently taking fluoride? _____How often? _____

Has your child been to the Dentist before? _____Date: _____

How was your child's experience? _____

Has your child had x-rays before? _____Date:_____

Is your child currently on the bottle? _____Pacifier? _____Sippy cup ? _____

Nursing? _____Thumb sucking? _____Grinding? _____

Do you currently help your child brush and floss? _____

How often does he/she brush? _____

Does your child have TMJ/TMD? _____

MEDICAL HISTORY:

Name of Physician:_____

Date of last physical exam: _____Any findings: _____

Is your child's immunization up to date? _____Date: _____

Date of your child's last tetanus _____Booster_____any immunizations due?_____

Is your child currently taking medication? _____If yes, what? _____

Is your child currently under the care of a physician for any reason? _____

If yes, for what? _____Date: _____

Has your child ever had a traumatic medical of dental injury? _____

If yes, for what? _____Date: _____

Has your child ever been hospitalized? _____

If yes, for what? _____Date: _____

DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?
PLEASE CICRLE ALL THAT APPLY TO YOUR CHILD:

Autism	Y				
ADHD	Y	Tubes in		Radiation Treatment	Y
AIDS	Y	ears	Y	Respiratory Treatment	Y
Allergies	Y	Endocrine		Respiratory Problem	Y
Anemia	Y	system	Y	Rheumatic Fever	Y
Artificial Joints	Y	Fainting	Y	Seizures	Y
Asthma	Y	Hearing/Sight	Y	Tuberculosis	Y
Blood disease/		Heart Murmur	Y	Down Syndrome	Y
disorder	Y	Heart Condition	Y	Vomiting/Diarrhea	Y
Blood		Head Injury	Y	Allergies/Adverse	
Transfusion	Y	Frequent/recurrent		reaction to medication	Y
If yes date _____		headache's	Y	If yes what type of	
Behavioral/		Kidney Disease	Y	medication? _____	
Learning disorder	Y	Liver Disease	Y	_____	
Breathing/Lung		Mental Disorder	Y	Frequent infections	Y
Problems	Y	Mental/Physical		What type _____	
Cancer/Tumor	Y	Developmental		_____	
Congenital birth		Delay	Y	Any other medical conditions	
Defects	Y	Pregnancy	Y	not listed _____	
Multiple ear		due date _____		_____	
Infections	Y	GI System	Y	_____	

I have read the above and have answered them to the best of my knowledge. I have updated this form as requested.

Signature_____Date_____

Signature_____Date_____

Signature_____Date_____