PATIENT'S NAME____
Last First Initial Date of Birth

PARENT'S NAME____
Last First Initial

DENTAL HISTORY (Please circle appropriate answer)

YES NO Is this the child's first dental visit?__________________
If not, when was the last appointment?________________
When were the teeth last cleaned?____________________
How many time a day does the child brush?____________
YES NO Do you live in an area without fluoridated water?
YES NO Have the teeth been treated with fluorides?
YES NO Were any teeth removed by extraction?
YES NO Was it suggested that the space be maintained?
YES NO Was appliance placed?
YES NO Has your child had any unfavorable dental experiences?
YES NO Has anyone in the family, including parents, had orthodontics?
YES NO Has a local anesthetic ever been used?
YES NO Has the child ever had occlusal sealants?
Describe any previous dental injuries____________________
____

COMMENTS

MEDICAL HISTORY

Name of Physician____

Please (X) if your child has, or had, any of the following

____Diabetes
____Heart Trouble
____Asthma
____Kidney Infection
____Rheumatic Fever
____Excessive Bleeding
____Ear Infection
____Toothache
____Fainting
____Dizziness
____Nervous Disorders
____Psychiatric Treatment
____Learning disabilities

Is your child allergic to:

____Penicillin ____Other Medications or Substances

____Antibiotics List: ____

List any medications your child is now taking____
____

Please explain any serious illness or surgery____
____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S /GUARDIAN'S SIGNATURE___________________________________DATE______________________

CHILD DENTAL / MEDICAL HISTORY