

Patient _____

Date of Birth _____

CONFIDENTIAL PATIENT MEDICAL HISTORY

Physician's Name _____ Phone Number _____ Date of Last Visit _____

Has your child ever been under the extended care of a physician or had any medical/dental surgeries? Yes No

Has your child ever broken a bone? Yes No

If yes, please explain: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- Heart Conditions (murmur, etc)
- Excessive Bleeding
- Diabetes
- Rheumatic Fever
- Liver Problems
- Cancer
- Hearing Loss
- HIV Positive
- Tuberculosis
- Asthma/Respiratory Problems
- Epilepsy
- Birth Defects
- Infections
- Hepatitis
- Frequent Headaches
- Kidney Infections
- Cerebral Palsy
- Eyesight Problems
- Speech Impairments
- Tubes in Ears

Is your child currently on any medications? Yes No If Yes: _____

Does your child have any allergies? (i.e. medications, food, latex or dyes) Yes No If Yes: _____

Is your child subject to any nervous disorders? Yes No If Yes: _____

CONFIDENTIAL PATIENT DENTAL HISTORY

Last Dentist's Name _____ Phone Number _____ Last Visit _____

Were any x-rays taken at your last dental visit? Yes No

Has your child had any problems with dental exams or treatment in the past? Yes No

Have any cavities been noted in the past? Yes No

Does your child eat between meals? Yes No

Does your child eat sweets? (candy, soda pop, chewing gum, fruit snacks, etc) Yes No

Has any family members ever needed orthodontics in the past? Yes No

Has your child ever received local anesthetic? Yes No

Has your child ever had occlusal sealants placed? Yes No

Has parent or caregiver been diagnosed with tooth decay in the past 2 years? Yes No

Has your child had any baby or permanent teeth extracted in the past? Yes No

If yes, was it suggested that the space be maintained? Yes No

Was an appliance placed? Yes No

Has your child experienced any trauma to the teeth? (falls, blows, chips, etc) Yes No

If yes, please explain: _____

How often does your child floss? _____

When does your child brush their teeth?

- Upon rising in the morning
- After eating any food
- After meals
- Before going to bed

How does your child currently receive fluoride?

- Community Water, ppm ____
- Well Water, ppm ____
- Drops or Tablets
- Rinse or Gels

Please describe your child's diet (regular/favorite foods): _____

****To help connect with your child please tell us about his/her interests (favorite sports, hobbies, TV Shows, movies, etc)**

Thank you for taking the time to fill this form out!

I certify that the above information is complete and accurate.

Parent/Guardian Signature: _____

Date: _____