



ABOUT YOUR CHILD

Child's Name (First) (MI) (Last)

M / F

Name child prefers to be called

Date of birth School (if applicable)

Reason for Visit:

Child's Hobbies:

Names of other children:

Referred by:

DENTAL HISTORY

Is this your child's first dental visit? Y / N

Previous dentist City, St

Date and nature of last visit

Any history of injuries to your child's teeth or jaws? Y / N
When & how?

Child finished nursing or bottle-feeding at age:

Habits (circle):

Thumb/finger sucking Now / In past

Pacifier Now / In past

Teeth grinding or clenching Now / In past

None

Has your child experienced any unfavorable reaction to previous medical or dental care? Y / N (If yes please explain)

How do you think your child will respond to dental treatment?

MEDICAL HISTORY

Physician's name Phone #

Emergency contact name Relationship

Address City/State Phone #

Is your child currently under the care of a physician for a specific medical problem? Yes No
If yes, what?

Is your child currently taking any prescription or over-the-counter medications? Yes No
If yes, what?

Has your child had a history of taking any medications frequently? Yes No
If yes, which ones?

Does your child take prescription fluoride? Yes No

Is your child allergic to any medication? Yes No
If yes, what?
What was the reaction?

Does your child have allergy to latex, dyes, or metals? Yes No
If yes, what?
What was the reaction?

Has your child ever been hospitalized or had surgery? Yes No
For what?

Has any member of your family, including your child, had a problem with general anesthetic? Yes No
If yes, describe:

Are your child's immunizations up to date? Yes No

Have you ever been told that your child requires antibiotics prior to dental treatment because of a heart defect or any other medical condition? Yes No

