welcome

PATIENT NUMBER

Patient's Name: _____ _____ _____
Last First Initial Nickname Date of Birth

DENTAL HISTORY - CHECK THE APPROPRIATE ANSWER

	Yes	No
1. Is this your child's first visit to a dentist?	☐	☐
2. If not, how long since the last visit to the dentist?		
3. Were any x-rays or radiographs taken when your child previously visited the dentist?	☐	☐
4. Does your child eat between meals?	☐	☐
5. Does your child eat sweets, such as candy, soda pop, chewing gum?	☐	☐
6. When does your child brush his/her teeth? ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed		
7. How does your child receive Fluoride? ☐ Community water level____ppm ☐ Well water level____ppm ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel		
8. Have any cavities been noted in the past?	☐	☐
9. Does your child suck his/her thumb or fingers?	☐	☐
10. Were any teeth (baby or permanent) removed by extraction?	☐	☐
Was it suggested that the space be maintained	☐	☐
Was an appliance placed	☐	☐
11. Have there been any injuries to teeth, such as falls, blows, chips, etc?	☐	☐
If so describe		
12. Has your child had any problem with dental treatment in the past?	☐	☐
13. Has anyone in the family, including parents, had orthodontics?	☐	☐
14. Has your child ever received a local anesthetic?	☐	☐
15. Has your child ever had occlusal sealants?	☐	☐
16. Does your child think there is anything wrong with his/her teeth?	☐	☐

MEDICAL HISTORY

1. Does your child have a health problem?	☐	☐
2. Is your child under care of physician?	☐	☐
If yes, since when and why? _____		
3. Name of physician _____ Phone _____		
4. Is your child receiving any medication?	☐	☐
What?		
5. Is your child allergic to penicillin, antibiotics or other drugs?	☐	☐
6. Is your child allergic to or sensitive to any metals or latex?	☐	☐
7. Does your child have other allergies?	☐	☐
8. Has your child had any serious illness?	☐	☐
When _____ What _____		
9. Has your child ever had surgery?	☐	☐
10. Does your child have a heart murmur?	☐	☐
11. Is surgery contemplated?	☐	☐
12. Does your child experience severe or prolongated bleeding?	☐	☐
13. Does your child have AIDS or has he/she tested HIV positive?	☐	☐
14. Has your child tested positive for hepatitis?	☐	☐
15. Is your child subject to nervous disorders?	☐	☐
Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems? ☐		
16. Does your child have frequent headaches?	☐	☐

17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, cognitive disability, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PARENT/GUARDIAN SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

Form No. TI31CDM

CHILD DENTAL MEDICAL HISTORY

MED. ALERT