

# Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## PATIENT'S DENTAL AND HEALTH HISTORY

INITIAL EXAM \_\_\_\_\_ DATE \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

CHILD'S ADDRESS \_\_\_\_\_ CHILD'S PHONE \_\_\_\_\_

HOBBIES, SPORTS AND INTERESTS \_\_\_\_\_

PERSON RESPONSIBLE FOR APPOINTMENTS \_\_\_\_\_ RESIDENCE PHONE \_\_\_\_\_

RESIDENCE ADDRESS \_\_\_\_\_

## DENTAL HISTORY

Please be specific by checking (✓) the box that applies to your child. Blank lines are available to use as needed for explanations.

CHIEF ORAL COMPLAINT \_\_\_\_\_

PREVIOUS DENTIST \_\_\_\_\_ PHONE # \_\_\_\_\_ DATE OF LAST DENTAL EXAM \_\_\_\_\_

ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE  YES  NO EXPLAIN \_\_\_\_\_

- Tooth Pain \_\_\_\_\_
- Traumatic injury to mouth or teeth \_\_\_\_\_
- Teeth sensitivity \_\_\_\_\_
- Bleeding gums \_\_\_\_\_
- Food impaction \_\_\_\_\_
- Clenching or grinding \_\_\_\_\_
- Swelling or lumps in mouth \_\_\_\_\_
- Frequent fever blisters or cold sores \_\_\_\_\_
- Pain around ear \_\_\_\_\_
- Bad breath \_\_\_\_\_
- Complications from extractions \_\_\_\_\_

- Orthodontic treatment \_\_\_\_\_
- Mouth breathing \_\_\_\_\_
- Oral habits, thumbsucking, fingernail biting, cheek biting, etc. \_\_\_\_\_
- Frequency of brushing \_\_\_\_\_
- Frequency of dental flossing \_\_\_\_\_
- Fluoride supplements \_\_\_\_\_
- Topical Fluoride Treatment \_\_\_\_\_
- Between meal snacks \_\_\_\_\_
- Well Balanced Diet \_\_\_\_\_

Is there any other information about your child's teeth or smile that might be of value to us? \_\_\_\_\_

Over Please

# MEDICAL HISTORY

PHYSICIAN'S NAME \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

CHILD'S AGE \_\_\_\_\_

Please be specific by checking (✓) the box that applies to your child. Blank lines are available to use as needed for explanations.

- |  |   |
|--|---|
| <input type="checkbox"/> Allergic to latex (rubber) _____                            | <input type="checkbox"/> Physical handicaps _____                       |
| <input type="checkbox"/> Allergic to any foods _____                                 | <input type="checkbox"/> Mental handicaps _____                         |
| <input type="checkbox"/> Allergic to Codeine _____                                   | <input type="checkbox"/> Congenital birth defects _____                 |
| <input type="checkbox"/> Allergic to local anesthetics _____                         | <input type="checkbox"/> ADHA _____                                     |
| <input type="checkbox"/> Allergic to Penicillin _____                                | <input type="checkbox"/> ADD _____                                      |
| <input type="checkbox"/> Allergic to any other Antibiotics? _____                    | <input type="checkbox"/> Rheumatic Fever _____                          |
| <input type="checkbox"/> Allergic to Barbituates, sedatives, or sleeping pills _____ | <input type="checkbox"/> Scarlet Fever _____                            |
| <input type="checkbox"/> Allergic to Aspirin _____                                   | <input type="checkbox"/> Skin Rash _____                                |
| <input type="checkbox"/> Allergic to Iodine _____                                    | <input type="checkbox"/> Immune System Disorders (AIDS, HIV, ARC) _____ |
| <input type="checkbox"/> Other? _____  | <input type="checkbox"/> Sinus problems _____                           |
| <input type="checkbox"/> Heart murmur _____  | <input type="checkbox"/> Thyroid disorders _____                        |
| <input type="checkbox"/> Heart problems _____  | <input type="checkbox"/> Eye disorders _____                            |
| <input type="checkbox"/> Mitral valve prolapse _____                                 | <input type="checkbox"/> Contact lenses _____                           |
| <input type="checkbox"/> Heart disease _____   | <input type="checkbox"/> Tonsil or Adenoid problems _____               |
| <input type="checkbox"/> Radiation treatment _____                                   | <input type="checkbox"/> Speech disorders _____                         |
| <input type="checkbox"/> Excessive bleeding _____                                    | <input type="checkbox"/> Hearing problems _____                         |
| <input type="checkbox"/> Anemia or blood problems _____                              | <input type="checkbox"/> Endocrine problems _____                       |
| <input type="checkbox"/> Asthma _____  | <input type="checkbox"/> Ulcer or Colitis _____                         |
| <input type="checkbox"/> Seasonal Allergies _____                                    | <input type="checkbox"/> Seizures _____                                 |
| <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> Epilepsy _____                                 |
| <input type="checkbox"/> Kidney problems _____                                       | <input type="checkbox"/> Lung or breathing problems _____               |
| <input type="checkbox"/> Liver problems or Hepatitis _____                           | <input type="checkbox"/> Tuberculosis _____                             |
| <input type="checkbox"/> Cancer _____  | <input type="checkbox"/> Extreme nervousness _____                      |
| <input type="checkbox"/> Psychiatric (mental) problems _____                         | <input type="checkbox"/> Ever taken Fen-Phen/Redux _____                |
| <input type="checkbox"/> Emotional problems _____                                    |   |

Please list any medications (including dosage and frequency) your child takes \_\_\_\_\_

Please list any drugs that have adverse reactions in your child. \_\_\_\_\_

List any other information that you feel might be of value to us in treating you child. \_\_\_\_\_

**To the best of my knowledge, the question on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or child's) health. It is my responsibility to inform the dental office of any changes in medical status.**

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

DATE