Personal Information

Patient Name: _____

Prefers to be Called: _____

Preferred Pharmacy (Name): _____ (Location): _____

Dental History

What is the primary reason for today's visit? _____

Is your child currently having problems with any of the following? Circle all that apply.

1.Cavities 2.Toothache 3.Sensitive Teeth 4.Trauma 5.Gum Infection 6.Color of Teeth 7.Tooth Alignment

8.Nail Biting 9.Thumb/Finger Sucking 10.Lipsucking/Biting 11.Nursing/Bottle Habits 12.Other:_____

Has the child experienced problems with previous dental work, including allergies or reactions to dental materials? YES NO

If yes, explain: _____

Does the child brush his/her teeth daily? YES NO Floss? DAILY WEEKLY NONE Parental Help? YES NO

Previous Dentist: _____ Date of last visit: _____

Medical History

Child's Physician: _____ Medical Group/Practice: _____

Phone #: (___) _____ Are immunizations current: YES NO

Please describe the child's current overall physical health: GOOD FAIR POOR

Has the child been diagnosed with or treated for any of the following: Circle all that apply.

1.Abnormal Bleeding 2.AIDS/HIV 3.Allergies 4.Allergic to Latex 5.Anemia 6.Asthma 7.ADD or ADHD

8.Autism Spectrum Disorder 9.Blood Transfusion 10.Blood Pressure High/Low 11.Brain Injury 12.Cancer

13.Cerebral Palsy 14.Cleft Palate/Lip 15.Diabetes 16.Ear Infections/Aches 17.Epilepsy/Convulsions

18.Endocrine Disorders 19.Feeding Tube 20.Handicaps/Disabilites 21.Hearing Impairment 21.Heart Problems of any Kind

22.Hemophilia 23.Hepatitis 24.Kidney/Liver Problems 25.Premature Birth 26.Psychiatric Problems

27.Rheumatic/Scarlet Fever 28.Spina Bifida 29.Tuberculosis 30.Other_____

If any checked above, please explain: _____

SENSORY ISSUES: 1.Light 2.Sound 3.Taste 4.Texture 5.Touch 6.Other: _____

Has the child ever been sedated or have they had any past operations? YES NO

If yes, please explain why and when: _____

Is the child currently under the care of a physician? YES NO

Please explain: _____

Please list all drugs that the child is currently taking: _____

_____

Has your child ever had an unusual reaction or allergy to any of the following drugs? Circle all that apply.

1.Penicillin 2.Aspirin 3.Acetaminophen 4.Ibuprofen 5.Codeine 6.Sulfa Drugs Other: _____

Does the child have any other known allergies of any kind? YES NO

If yes, please explain: _____

Anything you would like to discuss with the doctor in private today? YES NO

I affirm that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Parent/Guardian Signature: _____ Date: _____

Doctor Signature: _____