



Tell Us About Your Child

Today's Date: Child's Home Phone #: Social Security #: Child's Name: Child's Birthdate: Child's Age: Nickname: School: Grade: Child's Home Address: Who may we thank for referring you? Doctor Name: City: What is the primary reason for today's visit? Was your child adopted? Has any member of your family been or is currently a patient in this office? If yes, name:

Dental History

Is your child currently in pain? Is this your child's first dental visit? Has your child experienced problems with previous dental work? Previous Dentist: Date of Last Visit: Date of Last X-Ray: Why did you leave your previous dentist? What did you like most about any dentist you have seen? Least? Have there been any injuries to your child's teeth jaws, falls, blows, chips, etc. Does your child take fluoride vitamins or drink fluoridated water? Has your child been seen by an orthodontist? Does your child brush his / her teeth daily? Does your child floss his / her teeth daily? Who? Does he / she require parental help? Name of Parent's dentist: City: Phone:

Does / Did your child have any of the following habits? (please circle)

Lip Sucking and Nail Biting Clenching / Grinding Teeth Tongue / Cheek Biting Mouth Breather Chewing on Objects Thumb / Finger Sucking Used Pacifier Speech Problems TMJ / TMD Pain Nursing Bottle Habits Tongue Thrust Breast Fed

Medical History

Child's Physician: Phone: Date of last visit: Address: Is your child currently under the care of a physician? Please explain: Does your child have social/personality/temperament concerns that we should be aware of? Please describe your child's current physical health: Are Immunizations Current? Please list all medications and dosage that your child is currently taking: Please list all drugs and / or things that cause your child allergic reactions: Anything you would like to discuss with the Doctor in Private?

Has your child had / experienced any of the following: (please circle)

Abnormal Bleeding AIDS / HIV+ Allergies Anemia Any Hospital Stays Any Operations Asthma Blood Dyscrasia Blood Transfusion/Date Breathing / Lung Problems Cancer / Tumors Chicken Pox Congenital Birth Defect Congenital Heart Defect Diabetes Endocrine System Disorders Epilepsy Frequent Infections Handicaps Behavior / Learning / Disabilities Mentally / Physically Disabled Hearing Impaired Heart Murmur Hemophilia Hepatitis High Blood Pressure Hives Kidney Problems Liver / GI System Problems Low Blood Pressure Lupus Measles Mitral Valve Prolapse Mononucleosis Recurrent Headaches / Frequency Rheumatic Fever Seizures Scarlet Fever Sickle Cell Anemia Sight Disorders Significant Injuries / What Skin Rash Tonsillitis Tuberculosis (TB)

Please discuss any serious medical problems your child experiences(ed):

