MEDICAL/DENTAL HISTORY

Child's Physician Name ______________________ Phone ______________

Is your child currently under the care of a physician? Yes ☐ No ☐

Please describe your child's current physical health Good ☐ Fair ☐ Poor ☐

MEDICAL HISTORY

Has your child ever had any of the following conditions?

Condition	Yes	No	Condition	Yes	No
Abnormal Bleeding/Blood Disorder	Yes ☐	No ☐	Disabilities/Special Needs	Yes ☐	No ☐
ADD / ADHD	Yes ☐	No ☐	Hearing Impairment	Yes ☐	No ☐
Allergies to any Medications	Yes ☐	No ☐	Heart Disease/Murmur	Yes ☐	No ☐
Allergies to Latex/ Metal	Yes ☐	No ☐	Hemophilia/Blood Disorders	Yes ☐	No ☐
Any Hospital Stays/Operations	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	HIV + / AIDS	Yes ☐	No ☐
Autism	Yes ☐	No ☐	Kidney/Liver Conditions	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Pregnancy	Yes ☐	No ☐
Congenital Birth Defects	Yes ☐	No ☐	Rheumatic/Scarlet Fever	Yes ☐	No ☐
Convulsions/Epilepsy	Yes ☐	No ☐	Tuberculosis/Persistent Cough	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐		Yes ☐	No ☐

Please discuss any serious medical conditions your child has had ______________________

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Please list all medications your child is currently taking ______________________

____

Please list all medications your child is allergic to ______________________

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DENTAL HISTORY

Is this your child's first visit to the dentist? Yes ☐ No ☐ If not, when was the last visit? ____________

Previous Dentist's Name ______________________ Were x-rays taken at last visit? ________

Have there been any injuries to the teeth, face or mouth? ______________________

If yes, please explain ______________________

What would you like us to do for your child today? ______________________

Does the child have any of the following habits?

Habit	Yes	No	Habit	Yes	No
Lip Sucking / Biting	Yes ☐	No ☐	Nail Biting	Yes ☐	No ☐
Nursing / Bottle Habits	Yes ☐	No ☐	Thumb / Finger Sucking	Yes ☐	No ☐

Has your child ever had an adverse reaction or difficult problem associated with previous dental work? Yes ☐ No ☐

If yes, please explain ______________________

Has the child ever had any pain or tenderness in his/her jaw/joint? Yes ☐ No ☐

Does the child brush his/her teeth daily? Yes ☐ No ☐

Floss his / her teeth daily? Yes ☐ No ☐

I understand that the information 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. I authorize the dental staff to perform the necessary dental services my child may need.

Guardian's Signature ______________________ Date ____________

Doctor's Signature ______________________ Date ____________