Child's Name _____ Date_____
Child's Physician_____ Phone_____
Address_____ City_____ State_____ Zip_____
Date of last physical exam _____ Results_____
Is child under care of physician now? Yes__ No__ If yes, why_____

_____

Ever been hospitalized? ☐ Yes ☐ No If yes, why_____
Ever had surgery? ☐ Yes ☐ No If yes, why_____

Has child had any history of or difficulty with any of the following? Please check YES or NO

A.I.D.S./H.I.V.	☐ Y ☐ N	Cleft Lip/Palate	☐ Y ☐ N	Hay Fever	☐ Y ☐ N	Mental Disability	☐ Y ☐ N
Anemia	☐ Y ☐ N	Convulsions	☐ Y ☐ N	Hearing Problems	☐ Y ☐ N	Premature Birth	☐ Y ☐ N
Bladder Problems	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Heart Problem	☐ Y ☐	Rheumatic Fever	☐ Y ☐ N
Blood Transfusions	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Jaundice	☐ Y ☐ N	Sinus Problems	☐ Y ☐ N
Bruise Easily	☐ Y ☐ N	Fainting	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Cancer	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Cerebral Palsy	☐ Y ☐ N	Developmental Disability	☐ Y ☐ N	Other_____			

Any medications taken? ☐ Yes ☐ No Medications _____
Has child ever had any asthmatic attacks? ☐ Yes ☐ No If yes, Mild___ Moderate___ Severe___ Frequency _____
Comments_____

Is child allergic to, or ever had an adverse reaction to the following? If Yes, please circle

Aspirin Barbiturates Sedatives Sulfa Drugs Any Others_____
Amoxicillin Local Anesthetics Sleeping Pills Latex

Dental History

Is this your child's first time to a dental office? Yes__ No__ If no, please complete the following:
Name of previous dentist _____ Phone _____
Date of last visit to dentist _____ For what services_____
Has your child had any trouble associated with any previous dental treatment? ☐ Yes ☐ No If yes, please explain _____

_____

Have you been satisfied with your child's previous dental care? ☐ Yes ☐ No
Does child brush daily? ☐ Yes ☐ No Does child have sensitivity to hot/cold, sweet/sour? ☐ Yes ☐ No
Does child floss daily? ☐ Yes ☐ No Does child have pain to any of his/her teeth? ☐ Yes ☐ No
Has child ever had orthodontic work? ☐ Yes ☐ No Do gums bleed while brushing or flossing? ☐ Yes ☐ No
Is fluoride taken in any forms? ☐ Yes ☐ No Does child suck his/her thumb? ☐ Yes ☐ No
Does child bite lips, cheeks or nails? ☐ Yes ☐ No Does child use a pacifier or bottle? ☐ Yes ☐ No

Authorization

The information that I have given is correct to the best of my knowledge. I understand 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 for my child. I further understand that it is my responsibility to inform this office of any changes in my child's insurance coverage. I understand that where appropriate, credit bureau reports may be obtained.

Signature of Parent/Guardian _____ **Date** _____