



## Your Child's Dental History and Habits

Your Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_

**Welcome!** So that we may provide your child with the best possible care, please complete both sides of this dental/medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions.

What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

Your Child's Previous Dentist: \_\_\_\_\_

Date of your child's last dental visit: \_\_\_\_\_

When does your child brush? \_\_\_\_\_ Do you assist?.....Yes No

Does your child take Fluoride supplements?.....Yes No

Does your child have any dental problems now?.....Yes No If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Are any of your child's teeth sensitive to:

Hot or Cold?.....Yes No      Sweets?.....Yes No      Biting or Chewing?..... Yes No

Has your child had difficulty with previous dental visits?.....Yes No If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

How do you think your child will handle today's visit?  
\_\_\_\_\_

Does your child have any pain or tenderness in the jaw joint, ear, side of face?.....Yes No

Has your child complained about dental problems?.....Yes No

Do your child's gums bleed or hurt?.....Yes No

Has your child ever worn orthodontic appliances?.....Yes No

Does your child engage in:

Sucking thumb or fingers?.....Yes No

Chewing or biting

fingernails?.....Yes No

Chewing hard objects (e.g.

Biting or sucking lips or cheeks?.....Yes No

pencils)?.....Yes No

Clenching

Grinding teeth?.....Yes No

jaw?.....Yes No

Nursing bottle or pacifier

Mouth breathing?.....Yes No

habits?.....Yes No

Do you have any special concerns about your child's dental health?.....Yes No If yes, please describe: \_\_\_\_\_

# Your Child's Medical History

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Medical Alert \_\_\_\_\_

Who is accompanying this child today? \_\_\_\_\_  
Full Name (If Other Than Parent) Relation to child

Do you have Legal Custody of this child?....Yes No

**Mother's Name:** \_\_\_\_\_  
 \_\_\_\_\_  
(Check if same as child) Address City State Zip

Home phone# \_\_\_\_\_ Work phone# \_\_\_\_\_ Ext.. \_\_\_\_\_

Mother's Social Sec.# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Driver's License \_\_\_\_\_

Employer: \_\_\_\_\_  
 \_\_\_\_\_  
Emp. Address City State Zip

**Father's Name:** \_\_\_\_\_  
 \_\_\_\_\_  
(Check if same as child) Address City State Zip

Home phone# \_\_\_\_\_ Work phone# \_\_\_\_\_ Ext.. \_\_\_\_\_

Father's Social Sec.# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Driver's License \_\_\_\_\_

Employer: \_\_\_\_\_  
 \_\_\_\_\_  
Emp. Address City State Zip

**Primary Dental Insurance (Or Provide Card)**  
 Co. Name: \_\_\_\_\_  
 \_\_\_\_\_  
Address City State Zip

Insured's ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Name: \_\_\_\_\_

**Secondary Dental Insurance**  
 Co. Name: \_\_\_\_\_  
 \_\_\_\_\_  
Address City State Zip

Insured's ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Your Child's Physician: Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your child taking any medications? (prescription or over-the-counter).....Yes No  
 If yes, please describe \_\_\_\_\_

Have you ever been told your child needs antibiotics or premeds before treatment?.....Yes No

Does your child have any allergic (or adverse) reaction to any medication or other substance?..... Yes No  
 If yes, please describe \_\_\_\_\_

Are your child's immunizations current?.....Yes No

List any Hospitalizations, Surgeries, Serious Illnesses \_\_\_\_\_ When? \_\_\_\_\_



**Indicate which of the conditions your child has now or ever has had:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV positive           | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Lung problem              |
| <input type="checkbox"/> Allergies or Hives          | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Measles/Mumps             |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Mononucleosis             |
| <input type="checkbox"/> Behavioral/Learning problem | <input type="checkbox"/> Hearing problem        | <input type="checkbox"/> Nervous disorder          |
| <input type="checkbox"/> Bleeding disorder           | <input type="checkbox"/> Heart condition        | <input type="checkbox"/> Psychiatric/Psychological |
| <input type="checkbox"/> Brain Injury                | <input type="checkbox"/> Hepatitis _____        | <input type="checkbox"/> Rheumatic/Scarlet fever   |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Hyperactive/ADD        | <input type="checkbox"/> Sickle Cell Anemia        |
| <input type="checkbox"/> Cerebral palsy              | <input type="checkbox"/> Kidney/Liver problems  | <input type="checkbox"/> Stomach problem           |
| <input type="checkbox"/> Chicken pox                 | <input type="checkbox"/> Latex sensitivity      | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Cleft Lip/Palate            | <input type="checkbox"/> Leukemia/Anemia        | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Congenital heart disease    |   |  |

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will inform the office of any change in my child's health or medication.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_