|  |
| --- |
| Patient Information |
|  | *(First)* | *(Middle)* | *(Last)* | *(Nickname)* |
| **Name:** |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  Dental Information | **Yes** | **No** |  |  | **Yes** | **No** |
| **1.** | **Has your child ever been examined by another dentist?** |[ ] [ ]   **8.** | **What is your child’s attitude towards dentistry?** |  |  |
|  | Previous Dentist: | Last date: |  |  |  | [ ] Normal [ ] Shy [ ] Apprehensive [ ] Frightened |  |  |
| **2.** | **Has your child complained about any dental problems (pain, etc.)? Please specify area and how long:** |[ ] [ ]   **9.** | **Does your child have any mouth habits (check all that apply)?** |  |  |
|  |  |  |  |  |  [ ] Thumb sucking [ ] Finger Sucking [ ] Pacifier [ ] Tongue Thrust [ ] Mouth Breathing [ ] Nail Biting Other: |  |  |
| **3.** | **Has your child had any unpleasant dental experiences? Please specify:** |[ ] [ ]   **10.** | **Does your child have any speech difficulties? Please specify** |[ ] [ ]
|  |  |  |  |  **11.** | **Does your child brush their teeth daily?** |[ ] [ ]
| **4.** | **Has your child had any injuries to the mouth, teeth, or head? Please specify area of injury and date:** |[ ] [ ]   **12.** | **Do you assist your child with toothbrushing? Please specify how often:** |[ ] [ ]
|  |  |  |  |  |  |  |  |
| **5.** | **Have you ever been told by a dentist that your child has extra teeth or is congenitally missing any teeth?** |[ ] [ ]   **13.** | **Is dental floss used?** |[ ] [ ]
| **6.** | **Is your child currently nursing or taking a bottle?** |[ ] [ ]   **14.** | **Is fluoride taken (drinking water, tablets, drops)?** |[ ] [ ]
| **7.** | **Has your child ever worn any orthodontic appliances / braces?** |[ ] [ ]   |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  Medical Information | **Yes** | **No** |  |  | **Yes** | **No** |
| **1.** | **Is your child under the care of a physician now for any condition? Please specify below:** |[ ] [ ]   **7.** | **Does your child have any type of medical implant? Please specify below:** |[ ] [ ]
|  |  |  |  |  **8.** | **Does your child have a heart murmur, heart malformation or heart valve disorder? Please specify below:** |[ ] [ ]
| **2.** | **Is your child currently taking any prescription or over-the counter medications / supplements? Please specify below:** |[ ] [ ]   |  |  |  |
|  |  |  |  |  **9.** | **Has your child ever been diagnosed with a malignancy (cancer) or received radiation or chemotherapy treatment?** |[ ] [ ]
| **3.** | **Has your child ever been hospitalized or had surgery? Please specify below:** |[ ] [ ]   **10.** | **Is your child allergic to penicillin or any other medication?** |[ ] [ ]
|  |  |  |  |  **11.** | **Are there any other allergies (e.g. latex, foods, animals, pollen, etc.)?**  |[ ] [ ]
| **4.** | **Has your child ever had an unfavorable reaction to anesthesia?** |[ ] [ ]   **12.** | **Does your child have any special needs or physically / mentally challenged? Please explain below:** |[ ] [ ]
| **5.** | **Does your child have any type of bleeding disorder?** |[ ] [ ]   **13.** | **Does your child have any emotional problem?** |[ ] [ ]
| **6.** | **Have you ever been told by a physician that your child would need antibiotics before a dental procedure?** |[ ] [ ]   |  |  |  |
| Does your child have a history of, or difficulty with, any of the following? |
| [ ]  Anemia[ ]  Arthritis[ ]  Autism or Similar Condition[ ]  Cerebral Palsy[ ]  Developmental Delay[ ]  Diabetes | [ ]  Rheumatic Fever[ ]  Tuberculosis[ ]  Epilepsy or Other Seizure Disorder[ ]  Hepatitis or Other Blood-borne Pathogen | [ ]  Bladder[ ]  Heart[ ]  Kidney[ ]  Liver[ ]  Thyroid[ ]  Tonsils | [ ]  Hearing[ ]  Sight[ ]  Birth Anomaly[ ]  Genetic Disease[ ]  Other |
| Please explain and include any further information we need to be aware of: |
|  |
| **Child’s Physician:**  | **Address:**  | **Phone:**  |
| **Date of Last Physical Examination:**  | **Results:**  |

|  |  |
| --- | --- |
| **This information was given by:** |  |
| **Relation to Child:** |  | **Date:** |  |