|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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?** | |  |  |  |  |  |  |

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|  | 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:** | | | | | | | | |

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