



**PATIENT INFORMATION**

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Nickname \_\_\_\_\_  
Names and Ages of Brothers and Sisters \_\_\_\_\_  
Hobbies, Pets, Favorite TV Shows, etc. \_\_\_\_\_  
Person Responsible for this Account \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

**DENTAL HISTORY**

Reason for this visit (1<sup>st</sup> examination, check-up, toothache, etc.) \_\_\_\_\_  
\_\_\_\_\_  
Has your child ever had an injury to the mouth, teeth or jaws (fall, blow, etc.)? \_\_\_\_\_  
How long since last visit to a dentist? \_\_\_\_\_  
Was the dental experience pleasant or unpleasant? \_\_\_\_\_  
If unpleasant, how did he/she react? \_\_\_\_\_  
Has your child had Novocain? No  Yes  Has your child had laughing gas? No  Yes   
Does your child have any history of thumb or lip sucking, pacifier, nail or lip biting? If yes, please explain:  
\_\_\_\_\_  
Does your child use fluoride toothpaste? \_\_\_\_\_  
Has your child ever taken fluoride supplements or vitamins with fluoride? \_\_\_\_\_

**MEDICAL HISTORY**

Child's physician/pediatrician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Is your child in good health? \_\_\_\_\_ Is your child taking any medications? \_\_\_\_\_  
Is your child allergic to any medications? \_\_\_\_\_ General allergies? \_\_\_\_\_  
Any history of cerebral palsy, seizures, fainting, or loss of consciousness? No  Yes   
Any sensory disorders, ADHD or autism? No  Yes   
Any history of congenital heart disease, heart murmur or rheumatic fever? No  Yes   
Has any heart surgery been done or recommended? No  Yes   
Has your child ever had a blood transfusion? No  Yes   
Any history of anemia or sickle cell disease? No  Yes   
Does your child bruise easily or bleed excessively from small cuts? No  Yes   
Any history of pneumonia, cystic fibrosis, asthma, or difficulty breathing? No  Yes   
Any history of stomach, intestinal, kidney or liver problems? No  Yes   
Any history of hepatitis? No  Yes   
Any history of diabetes? No  Yes   
Any history of thyroid disease or other glandular disorders? No  Yes   
Has your child ever been hospitalized? No  Yes   
(If yes, please explain) \_\_\_\_\_  
Is your child up to date with immunizations? (DPT,IPV,MMR,Hib,HepB) No  Yes   
Any additional or related problem? \_\_\_\_\_

