DENTAL HISTORY □MALE □FEMALE
CHILD'S NAME: _____ DATE OF BIRTH: ____/____/____
ADDRESS: _____Zipcode _____
EMAIL: _____ PHONE: _____
How did you hear about us? _____
DOES YOUR CHILD HAVE AN UNUSUAL HISTORY OF THE FOLLOWING:
□ NURSING/BOTTLE HABITS □ PACIFIER □ THUMB/FINGER SUCKING □ DENTAL GRINDING
MEDICAL HISTORY
Name of Child's Physician: _____ Phone: _____
Is your Child taking any medications? □ Yes □ No
If yes, what medications? _____
Is your Child allergic to any of the following medications or substances? □ Yes □ No
□ Aspirin □ Penicillin □ Latex □ Food □ Metal/Acrylics □ Other: _____
PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

AIDS/HIV □ YES □ NO	CEREBRAL PALSY □ YES □ NO	GROWTH PROBLEMS □ YES □ NO	ORTHOPEDIC PROBLEMS □ YES □ NO
ANEMIA □ YES □ NO	CHEMOTHERAPY □ YES □ NO	HEART MURMUR/ HEART PROBLEMS □ YES □ NO	TOBACCO USE □ YES □ NO
ASTHMA/ PROBLEMS BREATHING □ YES □ NO	CHILD ABUSE □ YES □ NO	HEPATITIS/ LIVER DISEASE □ YES □ NO	PREGNANCY □ YES □ NO
AUTISM □ YES □ NO	CHRONIC ADENOID/ TONSIL PROBLEMS □ YES □ NO	HIGH BLOOD PRESSURE □ YES □ NO	ULCERS □ YES □ NO
ARTHRITIS □ YES □ NO	CLEFT LIP/PALATE □ YES □ NO	BLADDER CONDITIONS □ YES □ NO	DIABETES □ YES □ NO
ADHD □ YES □ NO	DEVELOPMENTALLY DELAYED □ YES □ NO	KIDNEY DISEASE □ YES □ NO	DISABILITY/ SPECIAL NEEDS □ YES □ NO
BIRTH DEFECTS □ YES □ NO	DRUG/ALCOHOL USE □ YES □ NO	LEUKEMIA □ YES □ NO	SPEECH/HEARING PROBLEMS □ YES □ NO
BRAIN INJURY □ YES □ NO	EMOTIONAL DISTURBANCE □ YES □ NO	SICKLE CELL ANEMIA □ YES □ NO	CONVULSIONS/ SEIZURES □ YES □ NO
BRUISE EASLIY □ YES □ NO	EXCESSIVE GAGGING □ YES □ NO	TUBERCULOSIS □ YES □ NO	TUMORS/ GROWTHS □ YES □ NO
BLEEDING/ CLOTTING PROBLEMS □ YES □ NO	FAINTING/ DIZZINESS □ YES □ NO	PROSTHETIC JOINTS/PINS □ YES □ NO	PSYCHIATRIC CARE □ YES □ NO
CANCER □ YES □ NO	FEVER BLISTERS □ YES □ NO		

If you answered "YES" to any of the above, please explain:
_____
_____

FIRST VISIT
PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
DENTIST SIGNATURE: _____ DATE: _____

Additional visits ensuring that medical history has been reviewed and any changes indicated.
PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
DENTIST SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
DENTIST SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
DENTIST SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
DENTIST SIGNATURE: _____ DATE: _____