Child's name: _____ Date of Birth: _____ Date: _____

Medical and Dental History

Your child's overall health, as well as any medications that he/she takes, may have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Medical History

Child's Physician: _____
Physician's Address: _____
_____
Date of Last Physical: _____
_____

Has your child ever had any of the following?

Asthma	yes	no
Cancer/Tumors	yes	no
Hepatitis	yes	no
HIV/Aids	yes	no
Hemophilia	yes	no
Diabetes	yes	no
Kidney Problems	yes	no
Liver/GI Problems	yes	no
Endocrine Abnormalities	yes	no
Allergies (seasonal)	yes	no
Allergies (food,drug)	yes	no
Explain _____		
Hearing Problems	yes	no
Eye Disorders	yes	no
Breathing/Lung Problems	yes	no
Blood Disorders	yes	no
Adverse Drug Reaction	yes	no
Rheumatic Fever	yes	no
Congenital Heart Defect	yes	no
Congenital Birth Defect	yes	no
Mental/Physical Development Delays	yes	no
Behavioral/Learning Problems	yes	no
Seizures/Epilepsy	yes	no
Social Development Delays	yes	no
Recurrent/Freq. Headaches	yes	no
Tuberculosis	yes	no
Frequent Infections	yes	no
Significant Injuries	yes	no
Explain _____		
Hospitalizations	yes	no
Explain _____		
Abnormal Bleeding	yes	no
History of Blood Transfusion	yes	no
Date _____		
Heart Ailments	yes	no
Heart Murmur	yes	no
Type _____		
Premed Needed	yes	no

Please explain any other medical problems that your child has _____
_____
_____.

Child's Medications

Please list your child's medications & dosages:
_____
_____
_____
_____

Dental History

What are your main concerns about your child's dental health? _____
_____
How frequently are your child's teeth brushed? _____
How frequently are your child's teeth flossed? _____
Do you help your child with brushing/flossing? yes no
Date of last dental visit _____ xrays _____
Previous Dentist _____
How would you describe your last dental experience?
_____
Does your child have a healthy diet? _____

Does your child's family have a history of dental decay or gum disease?	yes	no
Is your child's drinking water fluorinated?	yes	no
Does your child take fluoride supplement?	yes	no
If yes, dosage: _____		
Does your child:		
Suck thumb/finger/lips/pacifier?	yes	no
Bite/chew nails or hard objects?	yes	no
Grind teeth/clench jaws?	yes	no
Use a bottle/sippy cup?	yes	no
Breast feed/how long? _____	yes	no
Eat/drink after brushing?	yes	no
Brush before bed?	yes	no
Drink more than 1 glass of juice, tea, soda, or sports drink per day?	yes	no
Have a history of dental trauma?	yes	no

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such dental care to third party payers and/or health practitioners. I also consent to any necessary radiographs (x-rays) needed for proper diagnosis.

X _____
Signature of parent/guardian date