**Child's Name: _____** **Reason for today's visit: _____**

## Dental History

Is this your child's first visit to a dentist: Yes___ No____
If no, who was the previous dentist?

_____

Date of last dental visit: _____
Were any x-rays taken when your child previously visited the dentist? Yes___ No____
Has your child ever had a problem associated with dental treatment? Yes___ No____
Has your child ever had any pain in mouth or jaw? Yes___ No____
Has your child ever had any trauma to their head or neck? Yes___ No____
Does your child brush their teeth daily? Yes___ No____
Do you assist in brushing? Yes___ No____
Does your child floss daily? Yes___ No____
Do you assist in flossing? Yes___ No____

## Diet History

Does/Did your child:
Bottle feed? Yes___ No____ Age when stopped _____
Breast feed? Yes___ No____ Age when stopped _____
Snack more than twice a day? Yes___ No____
What does your child drink with meals? _____

_____

What does your child drink between meals? _____

_____

Does your child has any dietary restrictions? Yes___ No____
Does your child have an eating disorder? Yes___ No____
Does your child take fluoride supplements? Yes___ No____
WATER: City _____ Well _____ Bottled _____

## Medical History

Check any of the following which your child has had or presently has**:**

| | | |
|---|---|---|
| ☐ADD/ADHD | ☐Diabetes | ☐Mental Illness |
| ☐Allergies | ☐Down Syndrome | ☐Pregnancy |
| ☐Arthritis | ☐Emotional Impairment | ☐Premature Birth |
| ☐Artificial Joint/Valve | ☐Hearing Impairment | ☐Physical Impairment |
| ☐Asthma | ☐Hepatitis/Liver Disorder | ☐Seizure Disorder |
| ☐Autism | ☐High Blood Pressure | ☐Sickle Cell Anemia/Trait |
| ☐Bleeding Disorder | ☐HIV | ☐Speech Impairment |
| ☐Cancer | ☐Hospitalization | ☐Surgery |
| ☐Cerebral Palsy | ☐Kidney Disorder | ☐Tuberculosis |
| ☐Congenital Heart Defect | ☐Latex Sensitivity | ☐Vision Impairment |

## ☐ Check here if NONE apply

Please explain any of the above checked conditions or any serious medical conditions not listed: _____

_____

Please list all medications your child is currently taking: _____

_____

Please list all the medications your child has an allergic reaction to: _____

_____

Child's Physician: _____ Physician's Phone #: _____

Last Visit: _____

I understand that the above information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes to my child's medical status.

_____ _____

**Signature of Parent or Guardian** **Date**