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PATIENT NUMBER

PATIENT'S NAME _____
Last
First
Initial
Date of Birth

PARENT'S NAME _____
Last
First
Initial

CIRCLE THE APPROPRIATE ANSWER

DENTAL HISTORY

1. Is this the child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist? _____
3. When was the last time the teeth were cleaned? _____
4. Does child eat between meals? YES NO
5. Does child eat sweets, such as candy, soda pop, chewing gum? YES NO
6. Does child eat well balanced meals? YES NO
7. Does child brush teeth upon arising? YES NO
 - When going to bed? YES NO
 - Right after eating meals? YES NO
 - After eating any food? YES NO
8. Do you live in an area without fluoridated water? YES NO
9. Have teeth been treated with fluorides? YES NO
10. Have any cavities been noted in the past? YES NO
11. Were any teeth (baby or permanent) removed by extraction? YES NO
 - Was it suggested that the space be maintained? YES NO
 - Was appliance placed? YES NO
12. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
 - If so, describe _____
13. Has child had any unfavorable dental experiences? YES NO
14. How many children in your family? _____
15. Has anyone in the family, including parents, had orthodontics? YES NO
16. Has child ever received a local anesthetic or any form of anesthetic? YES NO
17. Has child ever had occlusal sealants? YES NO

COMMENTS

MEDICAL HISTORY

1. Is child in good health? YES NO
2. Is child under care of physician? YES NO
 - If yes, since when _____ Why _____
3. Name of physician _____
4. Is child receiving any medication? YES NO
 - When _____ Why _____
5. Has the child had any serious illness? YES NO
 - When _____ Why _____
6. Is the child allergic to penicillin, antibiotics or other drugs? YES NO
7. Does the child have any other allergies? YES NO
8. Has child had surgery? YES NO
9. Is surgery contemplated? YES NO
10. Is child subject to profuse bleeding? YES NO
11. Is child subject to nervous disorders? YES NO
 - Fainting? YES NO
 - Dizziness? YES NO
12. Has child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT