ALLIANCE FOR DENTAL CARE

ALL THE SERVICES – ALL THE CARE

CHILD DENTAL / MEDICAL HISTORY

Patient's Name _____
Last First I Date of Birth

Parent's Name _____

CIRCLE THE APPROPRIATE ANSWER

DENTAL HISTORY

1.	Is this the child's first visit to a dentist?……..	YES	NO
	If not, how long since the last visit to the dentist? _____		
2.	When was the last time the teeth were cleaned? _____		
3.	Does child eat between meals ? …….	YES	NO
4.	Does child eat sweets (candy, soda, gum)? ……	YES	NO
5.	Does child eat well balanced meals? ……..	YES	NO
6.	Does child brush teeth upon rising?……	YES	NO
	When going to bed? ……	YES	NO
	After eating any food? ……..	YES	NO
7.	Do you live in an area with flouridated water? ……	YES	NO
8.	Have teeth been treated with flourides? ……	YES	NO
9.	Have cavities been noted in the past? ……..	YES	NO
10.	Were any teeth removed by extraction? ……	YES	NO
11.	Was it suggested that space be maintained? …….	YES	NO
12.	Was appliance placed? ……	YES	NO
13.	Have there been any injuries to teeth (chips, blows, fall, etc)? If so, describe _____	YES	NO
14.	Has child had any unfavorable dental experience? ……	YES	NO
15.	How many children in your family? _____		
16.	Has anyone in the family had orthodontics? ……	YES	NO
17.	Has child ever received a local anesthetic or any form of anesthetic? …….	YES	NO
18.	Has child ever had occlusal sealants? ……..	YES	NO

MEDICAL HISTORY

1.	Is child in good health? ……..	YES	NO
2.	Is child under care of physician? If yes, since when? _____ Why?_____ _____…….	YES	NO
3.	Name of Physician _____		
4.	Is child receiving any medication? When? _____ Why?____ _____……..	YES	NO
5.	Has the child had any serious illness? When? _____ Why?_____ …….	YES	NO
6.	Is 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
12.	Fainting? ……	YES	NO
13.	Dizziness? ……	YES	NO
14.	Has child had history of : diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection? ……	YES	NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Parent's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____