



## DENTAL HISTORY

What would you like us to do for your child today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Does your child experience pain or discomfort in the jaw joint?  Y  N

Has your child ever experienced a mouth or chin injury?  Y  N

Does your child have speech problems? \_\_\_\_\_

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Other information about your child's dental health or previous treatment \_\_\_\_\_



## MEDICAL HISTORY



Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Has your child had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Is your child currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Has your child ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Has your child ever taken Fen-Phen/Redux?  Y  N

Check (  ) if your child has had any of the following:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Cough up blood     | <input type="checkbox"/> Hemophilia/Abnormal bleeding                                | <input type="checkbox"/> Shortness of breath            |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Immunizations current                                       | <input type="checkbox"/> Sinus problems                 |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Kidney disease or malfunction                               | <input type="checkbox"/> Skin rash                      |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Liver disease   | <input type="checkbox"/> Spina Bifida                   |
| <input type="checkbox"/> Blood disease          | <input type="checkbox"/> Food allergies     | <input type="checkbox"/> Material allergies ( <b>latex</b> , wool, metal, chemicals) | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Respiratory disease   | <input type="checkbox"/> Tonsillitis                    |
| <input type="checkbox"/> Chicken Pox            | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Rheumatic/Scarlet fever                                     | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Heart problems     |  | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Cough, persistent      | Describe _____                              |  |   |

List medications your child is taking, if any:

List drug allergies, if any:

## AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**