Dental History

Why did you bring the child to see the dentist today?

_____

Has the child ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin) If so, when?

Y N Is the child currently in pain? Does the child require antibiotics before dental treatment?

Y N Has the child ever had a serious/difficult problem assocaited with dental work?

Y N Is the child's water fluoridated?

Y N Is the child taking fluoridated supplements?

Y N Is the childs water, Well water?

Y N **Has the child ever had any pain/tenderness in in his/her jaw joint (TMJ/TMD)?**

Y N Does the child brush his/her teeth daily?

Y N Does the child floss his/her teeth daily?

Child / Parent Who brushes/ flosses the childs teeth?

Child's Physician:_____

Phone #: ( )_____ Date of Last Visit: _____

Y N Is the child currently under the care of a physician?

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list any drugs that the child is currently taking:

_____

Please list all drugs that the child is allergic to:

_____

_____

Y N Allergic to Latex Y N Allergic to Metals

Y N Allergic to Nickel Y N Allergic to Plastic

Medical History

Has the child experienced any of the following medical problems?

Y N A D /
Y N Ane ia
Y N Any os ital tays/ e ations
Y N A ti cial ones/ oints/ al es
Y N Asth a
Y N ance
Y N hic en Pox
Y N on enital ea t De ect
Y N on lsions
Y N Diabetes
Y N ile sy
Y N x osed to b t Ne
Y N Dental Phobia/ Anxiety
Y N in ash

Y N andica s/Disabilities
Y N ea in i ai ent
Y N Dea
Y N ea t
Y N e atitis
Y N i h lood P ess e
Y N i es
Y N idney P oble s
Y N i e P oble s
Y N ow lood P ess e
Y N s
Y N easles
Y N it al al e P ola se
Y N onon cleosis
Y N P osthetics
Y N he atic e e
Y N ca let e e
Y N be c losis

Are the child's immunizations current?

Is there anything you would like to discuss with the Doctor in Private?

Please discuss any serious medical problems the child experiences/ed:

_____

Does/did the child experience any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/finger Sucking
Y N Tongue/Cheek Sucking
Y N Tongue Thrust
Y N Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control made by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____ _____
Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, Please explain: _____

_____

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, Please explain: _____

_____

_____
Parent /Guardian Signature Date

_____
Dentist Signature Date

_____
Parent /Guardian Signature Date

_____
Dentist Signature Date