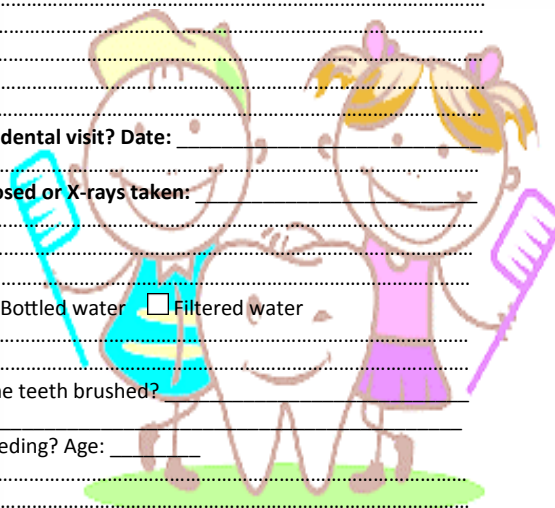


Patient's Name:		Nickname:	Date of Birth:	
Parent's/Guardian's Name:		Relationship to Patient:		
Address: <small>PO Box or Mailing Address</small>		City	State	Zip Code
Phone: ()	Home /Cell	Email:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Non binary <input type="checkbox"/>
Have you (the parent/guardian) or the patient had any of the following diseases or problems: 1. Active Tuberculosis 2. Persistent cough greater than a three-week duration 3. Cough that produces blood? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer yes to any of the three items above, please stop and return this form to the receptionist.				
Has the child had any history of, or condition related to, any of the following:				
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/AIDS	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Healthy	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bones/ Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell
Please list the name and phone number of the child's physician: Physician _____ Phone _____ - _____ - _____ Date of last physical exam: _____				

Child's History

		Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?		<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____			
2. Is the child allergic to any medications, i.e. Penicillin, antibiotics, or other drugs? If yes, please explain: _____		<input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods?		<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____			
4. How would you describe the child's eating habits? _____		<input type="checkbox"/>	<input type="checkbox"/>
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____		<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?		<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____		<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?		<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?		<input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?		<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?		<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally or emotionally impaired?		<input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?		<input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?		<input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to the dentist? If not, what was the date of the last dental visit? Date: _____		<input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?		<input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had a dental radiographs (x-rays) exposed? If yes, Date Exposed or X-rays taken: _____		<input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?		<input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?		<input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?		<input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		<input type="checkbox"/>	<input type="checkbox"/>
22. Does the child take fluoride supplements?		<input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?		<input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____		<input type="checkbox"/>	<input type="checkbox"/>
25. Do you floss your child's teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often: _____		<input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age: _____ Breastfeeding? Age: _____		<input type="checkbox"/>	<input type="checkbox"/>
27. Does child participate in active recreational activities?		<input type="checkbox"/>	<input type="checkbox"/>
28. Does the child such his/her thumb, fingers or pacifier?		<input type="checkbox"/>	<input type="checkbox"/>
29. What is the reason for your visit today?		<input type="checkbox"/>	<input type="checkbox"/>
30. How often does your child visit the dentist?		<input type="checkbox"/>	<input type="checkbox"/>
31. Name of former Dentist: _____		<input type="checkbox"/>	<input type="checkbox"/>



Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
 Parent's/Guardian's Signature _____ Date _____

For Completion by dentist
 Comments: _____