

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Male/Female: \_\_\_\_\_

### Child's Dental History

	Yes	No
Is your child having problems at this time? .....	<input type="checkbox"/>	<input type="checkbox"/>
If so, explain: _____		
Have there been any injuries to the teeth (falls, chips, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
When? _____ Where? _____ How? _____		
Has your child had any unfavorable dental experience?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, explain: _____		

### Child's Medical History

Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

	Yes	No
Is your child under any Medical Treatment now? If so, for what condition? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____		

Does your child currently take any medications? If so, list.....	<input type="checkbox"/>	<input type="checkbox"/>
_____		

Is your child up-to-date with vaccinations/immunizations?	<input type="checkbox"/>	<input type="checkbox"/>
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Has your child ever been hospitalized? If so, date: _____	<input type="checkbox"/>	<input type="checkbox"/>
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Reason: \_\_\_\_\_

Has your child ever had any serious head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>
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Does your child attend a special school? Name of the school _____	<input type="checkbox"/>	<input type="checkbox"/>
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Does your child have any allergies?.....	<input type="checkbox"/>	<input type="checkbox"/>
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Penicillin  Sulfa Drugs  Pain Medication  Local Anesthetic  Aspirin  Latex  Other \_\_\_\_\_

Has your child had or does your child have any of the following conditions?

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> Heart Problem     | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Seizure Disorder      | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Heart Defects at Birth |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Learning Disorder      |
| <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> AIDS Related Complex   |
| <input type="checkbox"/> Strep Throat      | <input type="checkbox"/> Tumor/Growths      | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Hearing Impairment  | <input type="checkbox"/> Arthritis/Joint Pain   |
| <input type="checkbox"/> Vision Impairment | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Other _____            |

\*Are there ANY behavioral or emotional conditions or problems that we should be aware of in order to better serve your child?  ADD/ADHD  PDD  Autism Spectrum Disorder  Anxiety Disorder  Other \_\_\_\_\_  
Explain \_\_\_\_\_

Is there any other Medical or Dental information that you feel we should know about your child's health? (Use Back if Needed) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_