Patient Name:________________________________ Chart #:___________________________

➪ Patient Dental History

Please answer the following questions:

Question	Yes	No
• Does your child brush, floss, or use any other dental aids?	❑	❑
• Is your child taking fluoride of any form?	❑	❑
• Do your child's gums bleed while brushing or flossing?	❑	❑
• Does your child feel pain to any teeth?	❑	❑
• Do you have any areas of concern?	❑	❑
• Has your child had any injuries to his or her mouth teeth or head?	❑	❑
• Has your child ever experienced clicking or pain of the jaw?	❑	❑
• Has your child ever experienced difficulty opening, closing, or chewing?	❑	❑
• Does your child breathe through his or her mouth?	❑	❑
• Does your child have frequent headaches?	❑	❑
• Does your child clench or grind his or her teeth?	❑	❑
• Do you assist your child while flossing and brushing?	❑	❑
• Are you pleased with the appearance of your child's smile?	❑	❑
• Has the mother or primary caregiver had cavities in the past 12 months?	❑	❑
• Does your child sleep w/ a bottle at night?	❑	❑
• Does your child's bottle or sippy cup contain fluid other than milk or water?	❑	❑
• Does your child suck his or her thumb and/or fingers?	❑	❑
• Does your child bite his or her nails	❑	❑
• Does your child enjoy chewing gum?	❑	❑
• Does your child drink sodas?	❑	❑

➪ Patient Medical History

Physician: ______________________________ Office Phone: ______________ Routine Exams? Yes No

1. Is your child under medical treatment now? Yes No
2. Has your child been hospitalized for any surgical operation or serious illness? Yes No
3. Does your child have or has your child had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Fainting/Seizures	❑	❑	Kidney or Liver Disease	❑	❑	Leukemia	❑	❑	Hepatitis	❑	❑
Low Blood Press.	❑	❑	Congenital Heart Defect	❑	❑	Cancer	❑	❑	Stomach Ulcers	❑	❑
High Blood Press.	❑	❑	Heart Murmur	❑	❑	Radiation Therapy	❑	❑	Hay Fever	❑	❑
Epilepsy	❑	❑	Heart Trouble	❑	❑	Tuberculosis	❑	❑	Allergies	❑	❑
Convulsions	❑	❑	Respiratory Problems	❑	❑	Hearing Impairment	❑	❑	Asthma	❑	❑
Abnormal Bleeding	❑	❑	Thyroid Problem	❑	❑	Diabetes	❑	❑	ADHD	❑	❑
Hemophilia	❑	❑				AIDS or HIV	❑	❑	Special Needs	❑	❑
Anemia	❑	❑				Jaundice	❑	❑	Other__________	❑	❑

4. Is your child taking any medications (including non-prescription medicines)? Yes No
5. If yes, what medications is he or she taking? ________________________________
6. If your child has asthma, when was his or her last episode? ________________________________
7. Is your child allergic to any of the following: (Please place a check beside which ones)
   ❑ Local anesthetics ❑ Aspirin ❑ Latex ❑ Iodine ❑ Sulfa Drugs ❑ Red Dye
   ❑ Penicillin or other antibiotics ❑ None ❑ Other:______________________

Authorization, Release, & Agreement to Pay for Services Rendered

- I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payers and/or health practitioners.
- I authorize and hereby request my insurance company to pay directly to the dentist (or the dental practice) insurance benefits that otherwise are payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services.
- I agree to be responsible for all services rendered on my behalf or on behalf of my dependents.
- I certify that I have read and understand the above information. To the best of my knowledge, the above answers have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

SIGNATURE X____ **DATE** ____________________