DENTAL INFORMATION

Patient First Name: _____ Last Name: _____Birth Date: _____

	Y	N	
Is/Was your child bottle fed?	☐	☐	If yes, until what age? _____
Is/Was your child breast fed?	☐	☐	If yes, until what age? _____
Does your child like to snack during the day?	☐	☐	If yes, what kind/how often?_____
Does your child drink juices/sweetened drinks?	☐	☐	If yes, what kind/how often?_____
Has your child ever had injuries to his teeth, mouth, head or jaws?	☐	☐	If yes, describe: _____
Does your child brush daily?	☐	☐	
Does an adult assist with the brushing?	☐	☐	
Does your child floss daily?	☐	☐	
Does an adult assist with the flossing?	☐	☐	
Did the mother/caregiver have cavities in the last year?	☐	☐	If yes, describe: _____

Does your child have any of the following mouth habits?

☐ Finger sucking ☐ Pacifier ☐ Lip sucking ☐ Teeth grinding

☐ Thumb sucking ☐ Tongue thrusting ☐ Mouth breather

Does your child receive fluoride in any of the following forms?

☐ Vitamins ☐ Water supply ☐ Tablets/drops Dosage: mg/day ☐ Toothpaste ☐ Rinse/gel

MEDICAL INFORMATION

Child's Pediatrician: _____ Address: _____ Phone: _____

Date of last physical? _____

	Yes	No
Is your child in good health?	☐	☐
Are your child's immunizations up to date?	☐	☐
Is your child being treated for any condition presently?	☐	☐
If so, explain: _____		
Is your child taking any medications or drugs?	☐	☐
If so, explain: _____		
Has your child ever been hospitalized or had surgery?	☐	☐
If so, explain: _____		
Does your child have any allergies or reactions to any medications?	☐	☐
If so, explain: _____		

Does your child have any allergies to the following: ☐ **pollen** ☐ **food / food dyes** ☐ **dust** ☐ **latex** **other** _____

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Chronic Headaches	☐	☐	Hemophilia
☐	☐	Allergies to Medication	☐	☐	Chronic Ear Infections	☐	☐	Hepatitis or Liver Disease
☐	☐	Anemia	☐	☐	Cleft Lip / Palate	☐	☐	Hyperactivity
☐	☐	Asthma/Lung Problems	☐	☐	Convulsions / Seizures	☐	☐	Kidney Disease
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Leukemia
☐	☐	Behavior/Language Problems	☐	☐	Endocrine System	☐	☐	Mental/Emotional Disturbances
☐	☐	Bladder Conditions	☐	☐	Epilepsy	☐	☐	Nutritional Deficiency
☐	☐	Blood Transfusions	☐	☐	Eye Problem	☐	☐	Oral Ulcers
☐	☐	Birth Defects	☐	☐	Excessive Bleeding Problem	☐	☐	Orthopedic Problems
☐	☐	Bone or Joint Problems	☐	☐	Excessive Gagging	☐	☐	Premature Birth
☐	☐	Brain Injury	☐	☐	Fainting or Dizziness	☐	☐	Rheumatic Fever
☐	☐	Bruising Easily/ Abnormal Bleeding	☐	☐	Frequent Infections	☐	☐	Sickle Cell Anemia
☐	☐	Cancer or Malignancies	☐	☐	Growth & Development Problems	☐	☐	Significant Injury
☐	☐	Cerebral Palsy	☐	☐	Hearing/Speech Problems	☐	☐	Syndrome _____
☐	☐	Child Abuse	☐	☐	Heart Problems	☐	☐	Other _____
☐	☐	Chronic Adenoid/Tonsil Infection						

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that has not been covered:

_____

Parent Signature: Date DDS Initials: