YOUR CHILD ** Today's Date ______________

Child's Name ____ Preferred First Name __________________
(First Name) (Last Name) (MI)

DOB __________________ Child's Age__________ □ Male □ Female SS#____________________________

MEDICAL HISTORY **

Is your child required to take ANTIBIOTICS BEFORE DENTAL PROCEDURES due to a medical condition? **___yes ___no**
Please explain: ____

Does your child have any ALLERGIES or sensitivities to any medicines, foods, dyes, latex or metals? **___yes ___no**
Please list allergies/sensitivities: ____

Is your child currently taking any MEDICATIONS, SUPPLEMENTS OR VITAMINS? **___yes ___no**
Please list: ____

Is your child currently under the care of a physician? ___yes ___no Name of Physician: _________________________
Please explain: ____

Does your child have or ever had any of the following:

___Abnormal Bleeding
___Anemia
___Any Hospital Stay/Operation
___Asthma
___Autism/Asperger's/ASD
___Birth Defects
___Blood Transfusion
___Cancer
___Cerebral Palsy
___Chronic Ear Infections
___Cystic Fibrosis
___Delayed Speech Development
___Developmental Delay
___Diabetes
___Down Syndrome
___Emotional/Psychiatric Problems
___Epilepsy/Seizures
___Food Allergies
___G-tube Feeding
___Hearing Loss/Impairment
___Heart Condition/Murmur
___Hepatitis
___HIV+/AIDS
___Hyperactivity/ADHD
___Kidney Disease
___Learning Disabilities
___Liver Disease
___Muscular Dystrophy
___Radiation Therapy
___Reflux/GERD
___Rheumatic Fever
___Seasonal Allergies
___Sickle Cell Anemia
___Skin Disorder
___Sleep Apnea/Snoring
___Spina Bifida
___Tonsillitis
___Tuberculosis
___Tumors

Please discuss any serious medical problems or other syndromes your child experiences/ed: _________________________
____

DENTAL HISTORY **

WHAT IS THE REASON FOR YOUR CHILD'S APPOINTMENT TODAY: __________________________________

FIRST VISIT TO ABC

Is your child currently in pain? ___yes ___no
Has your child had a toothache recently ___yes ___no
Is this your child's first visit to the dentist? ___yes ___no
If applicable, name of previous dentist: _______________
Date of last exam: ___________
Date of last x-rays: ___________
Would you like to remain with your child in the treatment area during appointments? ___yes ___no
How do you think your child will do today? _____________

BRUSHING HABITS

Do teeth get brushed every morning? ___yes ___no
Do teeth get brushed every evening? ___yes ___no
Who brushes teeth? ___child ___parent ___both
What kind of toothpaste?
___none ___without fluoride ___with fluoride

FLOSSING HABITS

How many times per week are teeth flossed? ______

NUTRITION AND SNACKING HABITS

Is your child currently breastfeeding? ___yes ___no
If so, nursing during the night? ___yes ___no
Does your child currently use a bottle? ___yes ___no
Does your child currently use a sippy cup? ___yes ___no
Beverages given in sippy cup: ___________________
Does your child snack frequently? ___yes ___no

ORAL HABITS

Does your child currently have any oral habits? ___yes ___no
___thumb sucking ___finger sucking ___pacifier
___grinding teeth ___other:____________________

ADDITIONAL DENTAL HISTORY

Has your child ever received any injuries to the head, jaw, mouth or teeth? ___yes ___no
Explain:______________________________________
Is there any family history (including siblings) of dental issues or cavities? ___yes ___no

Is there anything else about your child/your child's teeth that you think we should know in order to better treat the dental needs? ___yes ___no
Please explain: ____