



Children 12 & Under Medical and Dental History

Patient Name _____ D.O.B. _____

Parent/Guardian's Name _____ Relationship to Child _____

Emergency Contact (Name/Phone #) _____

Medical History

1. Does your child have any current health problems? Yes No

If yes, please explain: _____

2. Is your child under care of a physician? Yes No

Name of physician: _____

3. Is your child receiving any prescriptions, herbal, or OTC medications? Yes No

If yes, what and when? _____

4. Has your child had any serious illness? Yes No

If yes, what and when? _____

5. Has your child ever had surgery or is surgery contemplated? Yes No

If yes, please explain: _____

6. Does your child have a heart murmur or any other heart conditions? Yes No

7. Does your child experience severe or prolonged bleeding? Yes No

If yes, please explain: _____

8. Does your child have AIDS or has he/she tested HIV positive? Yes No

9. Has your child tested positive for hepatitis? Yes No

10. Has your child had a history of nervous disorders? Yes No

11. Does your child have frequent headaches? Yes No

If yes, please explain: _____

12. Is your child allergic/sensitive to: None Codeine Penicillin Local Anesthetic Latex

Pine Nuts Dyes Other: _____

13. Do you have, or have you ever had:

ADD/ADHD..... Yes No

Asthma Yes No

Autism..... Yes No

Behavioral problems Yes No

Cancer Yes No

Cerebral palsy Yes No

Developmental delay Yes No

Diabetes Yes No

Epilepsy/seizures/fainting Yes No

Eating disorders Yes No

Hay fever/seasonal allergies Yes No

Hearing impaired Yes No

Hepatitis/jaundice Yes No

Hospitalizations Yes No

Kidney infection Yes No

Liver problems Yes No

Leukemia Yes No

Oral herpetic lesions Yes No

School problems Yes No

Speech impairments Yes No

Thyroid problems Yes No

Rheumatic fever Yes No

Take pre-medication for anything? Yes No

If yes, what for? _____



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Dental History

- 1. This is my child's first visit to the dentist. Yes No
- 2. When does your child brush his/her teeth?
Upon arising After any food Right after meals Before bedtime
- 3. Do you currently monitor your child's sugar intake in food, snacks, and drinks? Yes No
- 4. Does your child receive Fluoride in their drinking water? Yes No
- 5. Does your child receive supplemental Fluoride at home? Yes No
- 6. Have any cavities been noted in the past? Yes No
- 7. Does your child suck his/her thumb or fingers? Yes No
- 8. Were any teeth (baby or permanent) removed by extraction? Yes No
- 9. Has a space maintainer been recommended? Yes No
- 10. Has a space maintainer been placed? Yes No
- 11. Has your child had any problem with dental treatment in the past? Yes No
- 12. Has anyone in the family, including parents, had orthodontics? Yes No
- 13. Has your child ever received a local anesthetic? Yes No
- 14. Has your child ever had occlusal sealants? Yes No
 If yes, when? _____
- 15. Does your child think there is anything wrong with his/her teeth? Yes No
- 16. Have there been any injuries to teeth, such as falls, blows, chips, etc.? Yes No
- 17. Does your child grind, clench, or brux their teeth? Yes No
 Explain: _____
- 18. Does your child snore? Yes No
- 19. Is there anything else that would be valuable for your dentist to know to best care for your child? Yes No
 Explain: _____

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my child's healthcare, advice, and treatment provided for the purpose of improved treatment outcomes and/or evaluating and administering claims for insurance benefits.
- I attest to the accuracy of the information on this page and understand that it is my responsibility to inform the Doctor and the office staff of any changes in my child's medical status at the very next appointment, before any further treatment is rendered.

Patient's/Guardian's Signature _____ Date _____

Dentist Signature _____ Date _____