Name:_____ **Birthdate:**____/____/____ **Male/Female:**____

Child's Dental History

	Yes	No
Is your child having problems at this time?	☐	☐
If so, explain: _____		
Have there been any injuries to the teeth (falls, chips, etc.).....	☐	☐
When?_____ Where?_____ How?_____		
Has your child had any unfavorable dental experience?.....	☐	☐
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?_____	☐	☐
_____		
Does your child currently take any medications? If so, list.....	☐	☐
_____		
Is your child up-to-date with vaccinations/immunizations?	☐	☐
Has your child ever been hospitalized? If so, date:_____	☐	☐
Reason:_____		
Has your child ever had any serious head injury?.....	☐	☐
Does your child attend a special school? Name of the school_____	☐	☐
Does your child have any allergies?.....	☐	☐

☐ Penicillin ☐ Sulfa Drugs ☐ Pain Medication ☐ Local Anesthetic ☐ Aspirin ☐ Latex ☐ Other _____

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

☐ Heart Problem	☐ Hepatitis	☐ Seizure Disorder	☐ Liver Disease	☐ Heart Defects at Birth
☐ Diabetes	☐ Ear Infections	☐ Mitral Valve Prolapse	☐ Asthma	☐ Learning Disorder
☐ Kidney Disease	☐ Prolonged Bleeding	☐ Tuberculosis	☐ Respiratory Disease	☐ AIDS Related Complex
☐ Strep Throat	☐ Tumor/Growths	☐ Jaundice	☐ Hearing Impairment	☐ Arthritis/Joint Pain
☐ Vision Impairment	☐ Rheumatic Fever	☐ Blood Disease	☐ HIV Positive	☐ 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**_____