Welcome to The Kids' Dentist

Patient's Name _____
Last First Initial Nickname Age

Parent's Guardian's Name _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. What is your chief concern today? _____
2. Is this your child's first visit to a dentist? …… YES NO
   If not, how long since the last visit to the dentist? _____
   Were any x-rays or radiographs taken when your child previously visited the dentist? .. YES NO
3. Does your child eat between meals? …… YES NO
   Does your child eat sweets, such as candy, soda pop, chewing gum? ……..... YES NO
4. When does your child brush his/her teeth?
   ڤ Upon arising ڤ After eating any food ڤ Right after meals ڤ Before going to bed
5. How does your child receive Fluoride?
   ڤ Community water level ___ ppm ڤ Well water level ___ ppm
   ڤ Fluoride drops or tablets ڤ Fluoride rinse or gel
6. Have any cavities been noted in the past? …… YES NO
7. Were any teeth (baby or permanent) removed by extraction? …… YES NO
   Was it suggested that the space be maintained? …….. YES NO
   Was an appliance placed? …… YES NO
8. Have there been any injuries to teeth, such as falls, blows, chips, etc? ……... YES NO
   If so, describe _____
9. Has your child had any problem with dental treatment in the past? …… YES NO
10. Has anyone in the family, including parents, had orthodontics? …… YES NO
11. Has your child ever received a local anesthetic? …… YES NO
12. Has your child ever had occlusal sealants? …….. YES NO
13. Does your child think there is anything wrong with his/her teeth? …….. YES NO

MEDICAL HISTORY

1. Does your child have a health problem? …….. YES NO
2. Is your child under care of physician? …… YES NO
   If yes, since when and why? _____
   Name of physician _____ Phone _____
3. Is your child receiving any medication? ……... YES NO
   What? _____
4. Is your child allergic to penicillin, antibiotics or other drugs? …… YES NO
5. Is your child allergic to or sensitive to any metals or latex? …… YES NO
6. Does your child have other allergies? …….. YES NO
7. Has your child had any serious illness? ……... YES NO
   When _____ What _____
8. Has your child ever had surgery? …… YES NO
9. Does your child have a heart murmur? …… YES NO
10. Does your child experience severe or prolonged bleeding? …… YES NO
11. Does your child have AIDS or has he/she tested HIV positive? …….. YES NO
12. Has your child tested positive for hepatitis? …… YES NO
13. Is your child subject to nervous disorders? …….. YES NO
    ڤ Fainting? ڤ Seizures? ڤ Dizziness? ڤ Behavioral/Learning problems?
14. Does your child have frequent headaches? …….. YES NO
15. Has your child had history of : (Circle Responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.
16. Describe any other medical concern _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _____

DATE _____

DENTIST'S SIGNATURE _____ DATE _____

CHILD DENTAL / MEDICAL HISTORY

Med. Alert