

CHILD DENTAL & MEDICAL HISTORY Name: _____

What are the main concerns that you would like to address? _____

Has your child ever been evaluated or had orthodontic treatment before? ___yes ___no

Does the child require antibiotics before dental treatment? ___yes ___no

Have adenoids or tonsils been removed? ___yes ___no

Does your child have any missing or extra permanent teeth? ___yes ___no

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ___yes ___no

Does the child brush his/her teeth daily? ___yes ___no

Child's Physician _____
Phone# _____ Date last visit ___/___/___

Is the child currently under the care of a physician? ___yes ___no

Has puberty begun? ___yes ___no

Has menstruation begun(female)? ___yes ___no

Please describe the child's current physical health: ___good ___fair ___poor

Please list all drugs that the child is currently taking at the present time _____

Aside from items listed below, list all drugs/things your child is allergic to:

Y N Latex Y N Nickel/Metal Y N Plastic

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature of parent/guardian Date

Has your child ever had any of the following medical problems?

- Y N Abnormal Bleeding
- Y N ADD/ADHD
- Y N Allergies to any Drugs
- Y N Allergic to Latex
- Y N Allergic to Metals
- Y N Allergic to Plastic
- Y N Any Hospital Stays
- Y N Any Operations
- Y N Artificial Bones/Joints
- Y N Asthma
- Y N Cancer
- Y N Congenital Heart Defect
- Y N Convulsions/Epilepsy
- Y N Diabetes
- Y N Handicaps/Disabilities
- Y N Hearing Impairments
- Y N Heart Murmur
- Y N Hemophilia
- Y N Hepatitis
- Y N HIV/AIDS
- Y N Kidney/Liver Problems
- Y N Lupus
- Y N Rheumatic/Scarlet Fever
- Y N Tuberculosis

Please discuss any medical problems that your child has had: _____

Has your child ever experienced any of the following?

- Y N Clenching/Grinding Teeth
- Y N Lip Sucking/Biting
- Y N Mouth Breather
- Y N Nail Biting
- Y N Speech Problems
- Y N Thumb/Finger Sucking
- Y N Tongue Thrust

I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent/guardian Date