

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth																																					
Parent's/Guardian's Name			Relationship to Patient																																						
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>																																									
Phone <small>Home Work</small>			Sex M <input type="checkbox"/> F <input type="checkbox"/>																																						
Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No																																									
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?																																									
<table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> HIV +/-AIDS</td> <td><input type="checkbox"/> Mononucleosis</td> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Cerebral Palsy</td> <td><input type="checkbox"/> Fainting</td> <td><input type="checkbox"/> Immunizations</td> <td><input type="checkbox"/> Mumps</td> <td><input type="checkbox"/> Tobacco/Drug Use</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> Growth Problems</td> <td><input type="checkbox"/> Kidney</td> <td><input type="checkbox"/> Pregnancy (teens)</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Bladder</td> <td><input type="checkbox"/> Chronic Sinusitis</td> <td><input type="checkbox"/> Hearing</td> <td><input type="checkbox"/> Latex allergy</td> <td><input type="checkbox"/> Rheumatic fever</td> <td><input type="checkbox"/> Venereal Disease</td> </tr> <tr> <td><input type="checkbox"/> Bleeding disorders</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Liver</td> <td><input type="checkbox"/> Seizures</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Bones/Joints</td> <td><input type="checkbox"/> Ear Aches</td> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Measles</td> <td><input type="checkbox"/> Sickle cell</td> <td></td> </tr> </table>						<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____	<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
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Name of Physician _____			Phone _____																																						

		Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... If yes, please list: _____	1.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2.	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3.	<input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____	4.	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized? .....	6.	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7.	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic? .....	8.	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems? .....	9.	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties? .....	10.	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion? .....	11.	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired? .....	12.	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut? .....	13.	<input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses? .....	14.	<input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15.	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past? .....	16.	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed? .....	17.	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth? .....	18.	<input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth? .....	19.	<input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment? .....	20.	<input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water			
22. Does the child take fluoride supplements? .....	22.	<input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used? .....	23.	<input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24.	<input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier? .....	25.	<input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____			
27. Does child participate in active recreational activities? .....	27.	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  Medical Alert  Premedication  Allergies  Anesthesia Reviewed by \_\_\_\_\_

Date \_\_\_\_\_