Patient Name: _____

1. Specific dental concerns you would like us to address: _____

Y N 2. First dental visit? If no, when was the last visit & with whom? _____

3. When does your child brush his/her teeth?

❒ Morning ❒ Between Meals ❒ Bedtime

Y N 6. Do you supervise the brushing?

Y N 7. Does your child floss?

For preschool children:

Y N 4. Does your child currently use a bottle or breast feed?

At what age did the child stop? _____ mos.

Y N 5. Does your child use a sippy cup between meals or at night?

8. What type of water sources do you use? ❒ City ❒ Well ❒ Bottled ❒ Other _____

9. Does your child consume any of the following on a daily basis: (check all that apply)

❒ Soda ❒ Chocolate/Strawberry Milk ❒ Juice ❒ Sweet Tea ❒ Chips ❒ Crackers/Dry Cereal ❒ Candy/Gum

Y N 10. Does your child suck a thumb or finger, use a pacifier, chew on fingernails or other materials? _____

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11. Name of child's pediatrician/physician: _____ Phone #_____

Y N 12. Is your child currently under the care of a physician? Date of Last Physical (Month/Year) _____

If yes, please explain: _____

Y N 13. Are your child's vaccinations current?

Y N 14. Does your child take any medication? Please list with dosage and frequency: _____

_____

Y N 15. Does your child have any allergies to medications, food, latex, or other materials?

Please list: _____

Y N 16. Has your child ever been admitted to a hospital, had surgery, or had a serious illness or injury?

Please list the date and reason: _____

_____

Does your child have a history of any of the following (circle all that apply):

Y N 17. Heart murmur or heart disease_____

Y N 18. Respiratory problems (asthma, reactive airway disease, tuberculosis, etc.) _____

Y N 19. Neurological disorders (epilepsy, seizures, cerebral palsy, shunts, ADD, autism, etc.) _____

Y N 20. Sight, hearing, or speech problems _____

Y N 21. Bleeding disorders, anemia, transfusions, HIV, etc. _____

Y N 22. Diabetes, lupus, arthritis, or auto-immune diseases _____

Y N 23. Premature birth (by how many weeks _____) _____

Y N 24. Liver disease, hepatitis, or jaundice _____

Y N 25. Kidney, stomach, or gastrointestinal disorders _____

Y N 26. Skin, bone, or muscle disorders _____

Y N 27. Leukemia, cancer, or tumors _____

28. Is there anything else we should know while treating your child? _____

X_____ _____ _____

Signature Date Your Relationship to the Child

Staff Notes:

_____

_____

_____

_____