Medical and Dental History for Children 12 and Under

Patient Name _____ D.O.B. _____

Parent/Guardian's Name _____Relationship to Child_____

Emergency Contact (Name/Phone Number) _____

Medical History

1. Does your child have any current health problems? ☐Yes☐No
   If yes, please explain _____
2. Is your child under care of a physician? ☐Yes☐No
   Name of physician _____
3. Is your child receiving any medications? ☐Yes☐No
   If so, what and when? _____
4. Has your child had any serious illness? ☐Yes☐No
   If so, what and when? _____
5. Has your child ever had surgery or is surgery contemplated? ☐Yes☐No
   Explain _____
6. Does your child have a heart murmur or any other heart condition? ☐Yes☐No
7. Does your child experience severe or prolonged bleeding? ☐Yes☐No
   Explain _____
8. Does your child have AIDS or has he/she tested HIV positive? ☐Yes☐No
9. Has your child tested positive for hepatitis? ☐Yes☐No
10. Has your child had a history of nervous disorders? ☐Yes☐No
11. Does your child have frequent headaches? ☐Yes☐No
    Explain _____
12. Is your child allergic/sensitive to: ☐None☐Codeine☐Penicillin☐Local Anesthetic☐Latex☐Pine Nuts☐Dyes
    ☐ Other _____
13. Has your child had history of:

Diabetes	☐Yes☐No	Cerebral palsy	☐Yes☐No
Asthma	☐Yes☐No	Cancer	☐Yes☐No
Hay fever	☐Yes☐No	Leukemia	☐Yes☐No
Kidney infection	☐Yes☐No	Oral Herpetic Lesion	☐Yes☐No
Liver problems	☐Yes☐No	Eating Disorders	☐Yes☐No
Hepatitis/ Jaundice	☐Yes☐No	Speech impairments	☐Yes☐No
Thyroid Problems	☐Yes☐No	Hearing Impaired	☐Yes☐No
Rheumatic fever	☐Yes☐No	Take pre-medication for anything	☐Yes☐No
Epilepsy/ Seizures/ Fainting	☐Yes☐No	If yes, what for _____	

Dental History

1. This is my child's first visit to the dentist. ☐ Yes ☐ No
2. When does your child brush his/ her teeth?
   ☐ Upon arising ☐ After any food ☐ Right after meals ☐ Before bedtime
3. Do you currently monitor your child's sugar intake in food, snacks and drinks? ☐ Yes ☐ No
4. Does your child receive Fluoride in their drinking water? ☐ Yes ☐ No
5. Does your child receive supplemental Fluoride at home? ☐ Yes ☐ No
6. Have any cavities been noted in the past? ☐ Yes ☐ No
7. Does your child suck his/her thumb or fingers? ☐ Yes ☐ No
8. Were any teeth (baby or permanent) removed by extraction? ☐ Yes ☐ No
9. Has a space maintainer been recommended? ☐ Yes ☐ No
10. Has a space maintainer been placed? ☐ Yes ☐ No
11. Has your child had any problem with dental treatment in the past? ☐ Yes ☐ No
12. Has anyone in the family, including parents, had orthodontics? ☐ Yes ☐ No
13. Has your child ever received a local anesthetic? ☐ Yes ☐ No
14. Has your child ever had occlusal sealants? ☐ Yes ☐ No
    If so, when _____
15. Does your child think there is anything wrong with his/her teeth? ☐ Yes ☐ No
16. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ☐ Yes ☐ No
17. Does your child grind, clench or brux their teeth? ☐ Yes ☐ No
    Explain _____
18. Does your child snore? ☐ Yes ☐ No
19. Is there anything else that would be of valuable for your dentist to know to best care for you? ☐ Yes ☐ No
    Explain _____

- I authorize the dentist to perform diagnostic procedures and treatment as deemed necessary for proper dental care.
- I authorize the release of any information concerning my child's healthcare, advice and treatment provided for the purpose of improved treatment outcomes and/or evaluating and administering claims for insurance benefits.
- I attest to the accuracy of the information on this page and understand that it is my responsibility to inform the Doctor and the office staff of any changes in my child's medical status at the very next appointment, before any further treatment is rendered.

Patient's / Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____