Child's History
These questions are of great value in aiding us in the treatment and better understanding of your child.



Last First Initial Michael Male Female Birthplace Birthplace	Child's Name				
Perent(s)/Guardian(s) name DENTAL INFORMATION: Family Dentist Phone No. Is there a particular situation you would like examined today? yes no If "yes" explain:	Last	First	Initial n	ickname	
DENTAL INFORMATION: Family Dentist	☐ Male ☐ Female Birthdate _		Birthplace		
Family Dentist	Parent(s)/Guardian(s) Name				
2. When was your child's last dental checkup and cleaning? 3. Has your child been seeing a dentist for regular checkups and care? yes no 4. Has your child had any negative experiences with dentists or doctors? yes no 4. Has your child had any negative experiences with dentists or doctors? yes no What, if any: 5. Taking Fluoride? yes no MEDICAL INFORMATION: Child's Physician	DENTAL INFORMATION:				
2. When was your child's last dental checkup and cleaning? 3. Has your child been seeing a dentist for regular checkups and care? yes no 4. Has your child had any negative experiences with dentists or doctors? yes no 4. Has your child had any negative experiences with dentists or doctors? yes no What, if any: 5. Taking Fluoride? yes no MEDICAL INFORMATION: Child's Physician	Family Dentist Phone No				
3. Has your child been seeing a dentist for regular checkups and care?	1. Is there a particular situation you would l	ike examined	d today? 🔲 Yes 🔲 No If "yes" explain:.		
3. Has your child been seeing a dentist for regular checkups and care?					
4. Has your child had any negative experiences with dentists or doctors? yes no What, if any: 5. Taking Fluoride? yes no MEDICAL INFORMATION: Child's Physician Phone No. 1. Does your child have or has your child ever had any of the following: A) Heart disease, murmur or rheumatic fever? yes no money yes no If YES, antibiotic documentation with be required from patients physician. B) High or low blood pressure n) Lung disease (TB, asthma,, persistent cough, other) C) Hay fever, sinus problems, or altergies n) Epilepsy, seizures, fainting spelts n) Herpes or cold sores p) Arthritis n) Herpes or cold sores p) Arthritis n) Herpes or cold sores p) Arthritis n) Herpes or cold sores n) Sore throats, tonsititis, earaches n) Household for the following n) Household for the following n) Almormal bleeding or blood disorders ff yes, what n) Smoke or use other forms of tobacco n) Radiation or chemotherapy n) Any other major itiness, surgery or conditions n) Radiation or chemotherapy n) Any other major itiness, surgery or conditions n) Radiation or chemotherapy n) The Smoke or use other forms of tobacco n) Radiation or chemotherapy n) The following n) The foll					
MEDICAL INFORMATIOn: Child's Physician	3. Has your child been seeing a dentist for i	regular chec	kups and care? LJ yes LJ no	_	
MEDICAL INFORMATION: Child's Physician	4. Has your child had any negative experiences with dentists or doctors? LJ Yes LJ No What, if any:				
Child's Physician	5. Taking Fluoride?				
1. Does your child have or has your child ever had any of the following: A) Heart disease, murmur or rheumatic fever? IF YES, antibiotic documentation will be required from patient's physician. B) High or low blood pressure C) Hay fever, sinus problems, or allergies D) Herpes or cold sores D) Herpes or cold sores P) Arthritis E) Diabetes F) Emotional problems R) Venereal disease F) Emotional problems R) Venereal disease F) Emotional problems R) Venereal disease D) Radiation or chemotherapy H) Cancer, tumors, other growths T) Smoke or use other forms of tobacco D) Radiation or chemotherapy D) Radiation or other pain medication Foods Appiring or other pain medication Foods Foods Appiring or other pain medication Foods Food	MEDICAL INFORMATION:				
A) Heart disease, murmur o rheumatic fever? IF YES, antibiotic documentation will be required from patient's physician. B) High or low blood pressure	Child's Physician Phone No				
A) Heart disease, murmur or neumatic fever? IF YES, antibiotic documentation will be required from patient's physician. B) High or low blood pressure C) Hay fever, sinus problems, or altergies D) Herpes or cold sores D) Herpes or cold sores D) Herpes or cold sores D) Horpes or cold sorts D) Horpes or cold sores D) Horpes or cold sorts	1. Does your child have or has your child ever had any of the following:				
C) Hay fever, sinus problems, or altergies D) Epilepsy, seizures, fainting spells D) Herpes or cotd sores D) Arthritis E) Diabetes D) Sore throats, tonsititis,, earaches Autism C) Kidney disease C) S) Abnormal bleeding or blood disorders If yes, what H) Cancer, tumors, other growths D) Radiation or chemotherapy D) Reactions or altegies to any of the following: C) Aspirin or other pain medication Foods Antibiotics Dental Anesthetics Other (food dye, flavorings, etc.) K) Immunologic deficiency disease Does he/she know? D) Has your child been treated or currently being treated for any chaemical dependency?	IF YES, antibiotic documentation will be required	yes no	M) Thyroid problems	yes no	
C) Hay fever, sinus problems, or altergies	B) High or low blood pressure				
E) Diabetes	C) Hay fever, sinus problems, or allergies		•		
R) Venereal disease	D) Herpes or cold sores		P) Arthritis		
Autism G) Kidney disease S) Abnormal bleeding or blood disorders If yes, what H) Cancer, tumors, other growths T) Smoke or use other forms of tobacco U) Any other major illness, surgery or conditions If yes, what J) Reactions or allegies to any of the following: Aspirin or other pain medication Foods Antibiotics Dental Anesthetics Other (food dye, flavorings, etc.) K) Immunologic deficiency disease Does he/she know? Y) Has your child been treated or currently being treated for any chaemical dependency?	E) Diabetes		Q) Sore throats, tonsilitis,, earaches		
S) Abnormal bleeding or blood disorders	F) Emotional problems		R) Venereal disease		
H) Cancer, tumors, other growths T) Smoke or use other forms of tobacco U) Any other major illness, surgery or conditions if yes, what J) Reactions or allegies to any of the following: Aspirin or other pain medication Foods Antibiotics Dental Anesthetics Other (food dye, flavorings, etc.) K) Immunologic deficiency disease Does he/she know? Y) Has your child been treated or currently being treated for any chaemical dependency?	☐ Autism				
Description	G) Kidney disease				
J) Reactions or allegies to any of the following: Aspirin or other pain medication Foods Antibiotics Other (food dye, flavorings, etc.) K) Immunologic deficiency disease L) Liver Disease (Hepatitis, Jaundice) If yes, what W) Take any drugs or medications, prescription or non-prescription If yes, what N) Take any drugs or medications, prescription or non-prescription If yes, what N) Is your child adopted? N) Is your child adopted? Y) Has your child been treated or currently being treated for any chaemical dependency?	H) Cancer, tumors, other growths		T) Smoke or use other forms of tobacco		
Aspirin or other pain medication Foods Latex Antibiotics Dental Anesthetics Other (food dye, flavorings, etc.) K) Immunologic deficiency disease Does he/she know? Yes Disease (Hepatitis, Jaundice) W) Take any drugs or medications, prescription or non-prescription lf yes, what X) Is your child adopted? Does he/she know? Pyes Does he/she know? Wes Does he/she know? Pyes Does he/she kn	I) Radiation or chemotherapy				
Foods Latex Or non-prescription If yes, what X) Is your child adopted? K) Immunologic deficiency disease Does he/she know? Yes no L) Liver Disease (Hepatitis, Jaundice) Y) Has your child been treated or currently being treated for any chaemical dependency?	J) Reactions or allegies to any of the following:		V) ADD or ADHD		
K) Immunologic deficiency disease Does he/she know? yes no L) Liver Disease (Hepatitis, Jaundice) Y) Has your child been treated or currently being treated for any chaemical dependency?	Foods Latex Antibiotics Dental Anesthetics		or non-prescription		
L) Liver Disease (Hepatitis, Jaundice) Y) Has your child been treated or currently being treated for any chaemical dependency?			X) Is your child adopted?	\sqcup \sqcup	
being treated for any chaemical dependency?	K) Immunologic deficiency disease		Does he/she know? ☐ Yes ☐ No		
Signed Date	L) Liver Disease (Hepatitis, Jaundice)				
	Signed		Date		