Travis R. White, DMD
Kolby J. Lance, DMD
John C. Dryden, DMD

Dental / Medical History…

CHILD'S NAME: First _____ Last _____ MI _____

DENTAL HISTORY:

Why is your child here today? _____

Is your child currently taking Fluoride? □Yes □No How Often? _____ Dose? _____

Has your child been to the dentist before? □Yes □No Date? _____ Dentist? _____

How was your child's experience? _____

Has your child had x-rays before? □Yes □No Date last taken? _____

Is your child currently using a **Bottle?** □Yes □No **Pacifier?** □Yes □No **Sippy Cup?** □Yes □No

Nursing? □Yes □No **Thumb sucking?** □Yes □No **Grinding?** □Yes □No

Any other habits or concerns? _____

Do you currently help your child **brush?** □Yes □No **Floss?** □Yes □No

How often does he/she brush? _____ Floss? _____

Does your child have TMJ/TMD? □Yes □No **Explain**: _____

MEDICAL HISTORY:

Health problems, or medications that your child is taking, could have an important inter-relationship in the dentistry your child receives. Thank you for answering all of the following questions.

Name of Physician: _____

Date of last physical exam: _____ Any Findings: _____

Receiving Physician Care for reason other than Well Child Checks? _____

Are your child's immunizations up to date? □Yes □No Immunizations due: _____

Date of child's last Tetanus booster: _____

List all medications your child is taking: _____

_____

Has your child ever been Hospitalized? □Yes □No **Explain**: _____

Has your child had any Surgery? □Yes □No **Explain**: _____

Has your child ever had a serious head or neck injury? □Yes □No **Explain**: _____

Has your child ever had a traumatic dental injury? □Yes □No **Explain**: _____

Is your child allergic to any of the following? □**Aspirin** □**Penicillin/Amoxicillin** □**Codeine** □**Metal** □**Latex**

□**Local anesthesia** □**Other**: _____

Please Turn form over and complete other side.

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? Please Circle as they apply to your child

Autism	Yes	No
ADHD	Yes	No
AIDS	Yes	No
Allergies to Medication	Yes	No
Artificial Joints	Yes	No
Asthma	Yes	No
Blood Disease / Disorder	Yes	No
Specify: _____		
Blood Transfusion	Yes	No
If yes Date: _____		
Behavior / Learning Problems	Yes	No
Breathing / Lung Problems	Yes	No
Cancer / Tumor	Yes	No
Radiation Therapy	Yes	No
Congenital Birth Defects	Yes	No
Cortisone/Prednisone therapy	Yes	No
Multiple Ear Infections	Yes	No
Tubes in Ears	Yes	No
Diabetes	Yes	No
Insulin Dependent	Yes	No
Endocrine Disorder	Yes	No
Fainting / Spells	Yes	No
Hearing Problems	Yes	No
Sight Problems	Yes	No
Heart Murmur	Yes	No
Heart Condition	Yes	No
Antibiotics needed:	Yes	No

Head Injury	Yes	No
Frequent Headaches	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Mental Disorder	Yes	No
Developmental Delay	Yes	No
Pregnancy	Yes	No
Due Date: _____		
GI System Disorder	Yes	No
Respiratory Disorder	Yes	No
Treatment: _____		
Rheumatic Fever	Yes	No
Seizure Disorder	Yes	No
Type/Medication: _____		
Tuberculosis	Yes	No
Down Syndrome	Yes	No
Other syndrome: _____		
Vomiting/Diarrhea	Yes	No
Seasonal Allergies	Yes	No
Frequent Infections	Yes	No
What Type: _____		
Any other Medical conditions not listed? _____		

Any comments that you feel the Doctor should know about your child's health? _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical/health status.

SIGNATURE OF PATIENT, PARENT, or GAURDIAN _____ DATE: _____