WILLIAMSON family dentistry

CHILD DENTAL & MEDICAL HISTORY

Patient's Name_____
Last First Initial Nickname

Date of Birth _____/_____/_____ **Parent's/Guardian's Name**_____
Last First Initial

DENTAL HISTORY

1. Is this your child's first visit to a dentist? ( )Yes ( )No Dr.'s Review/Comment
   If yes, please skip to question #9.
2. How long since the last visit?_____
3. Were any x-rays taken when your child previously saw a dentist? ( )Yes ( )No
4. Have any cavities been noted in the past? ( )Yes ( )No
5. Were any teeth (baby or permanent) removed by extraction? ( )Yes ( )No
   If yes, was it suggested that the space be maintained? ( )Yes ( )No
   If yes, was an appliance placed? ( )Yes ( )No
6. Has your child had any problems with dental treatment in the past? ( )Yes ( )No
   If yes, please describe_____
7. Has your child ever received a local anesthetic? ( )Yes ( )No
8. Has your child ever had occlusal sealants? ( )Yes ( )No
9. Does your child eat between meals? ( )Yes ( )No
10. Does your child eat sweets (i.e., candy, soda pop, chewing gum)? ( )Yes ( )No
11. When does your child brush his/her teeth?
    ( ) Upon waking ( ) After eating any food ( ) After meals ( ) At bedtime
12. How does your child receive Fluoride?
    ( ) City water ( ) Well water ( ) Fluoride drops/tablets ( ) Fluoride rinse/gel
13. Have there been any injuries to teeth (i.e., falls/blows, and chips)? ( )Yes ( )No
    If yes, please describe_____
14. Does your child think there is anything wrong with his/her teeth? ( )Yes ( )No
15. Do you have any concerns about your child's teeth? ( )Yes ( )No

MEDICAL HISTORY

1. Does your child have any health problems? ( )Yes ( )No
2. Name of child's physician_____
3. Is your child receiving any medications? ( )Yes ( )No
   If yes, please list_____
4. Is your child allergic to penicillin, antibiotics or other drugs? ( )Yes ( )No
   If yes, please list the specific drug(s)_____
5. Does your child have other allergies? ( )Yes ( )No
   If yes, please describe_____
6. Has your child ever had a serious illness? ( )Yes ( )No
   If yes, please describe_____
7. Has your child ever had surgery? ( )Yes ( )No
   If yes, please describe_____
8. Does your child have a heart murmur? ( )Yes ( )No
9. Does your child experience severe or prolonged bleeding? ( )Yes ( )No
10. Has your child tested positive for hepatitis? ( )Yes ( )No
11. Has your child tested positive for HIV/AIDS? ( )Yes ( )No
12. Please check if your child is subject to any of the following:

( ) Fainting	( ) Dizziness	( ) Behavioral/Learning Difficulty	( ) Diabetes
( ) Heart Trouble	( ) Epilepsy	( ) Speech Impairments	( ) Liver Problems
( ) Kidney Infection	( ) Cerebral Palsy	( ) Rheumatic Fever	( ) Cancer
( ) Asthma	( ) Infections	( ) Congenital Birth Defects	( ) Eyesight Problems
( ) Hearing Loss	( ) Mental Retardation		

Date
Dr.'s Initials

I certify that the above information is complete and accurate to the best of my knowledge.

PARENT'S/GUARDIAN'S SIGNATURE_____ **DATE**_____