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Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_ /\_\_\_/\_\_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Your Child’s Physician Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Medical Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child taking any medication(s)? Yes No Don’t Know

If yes, list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child allergic to any medication, anesthetic solutions, latex, or foods?

 Yes No Don’t Know

If yes, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child had a serious illness? Yes No Don’t Know

When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child ever had surgery? Yes No Don’t Know

­­­­­­­­­­­­­­­­­­­Has your child ever been treated in the emergency room? Yes No Don’t Know

List age and reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child have any history of:
* Heart murmurs? Yes No Don’t Know
* Rheumatic Fever? Yes No Don’t Know
* Blood or bleeding disorders? Yes No Don’t Know
* Birth defects or genetic disorders? Yes No Don’t Know
* Growth or developmental disorders? Yes No Don’t Know
* Convulsions, fainting or seizures? Yes No Don’t Know
* Cerebral palsy? Yes No Don’t Know
* Ear, nose, or throat problems? Yes No Don’t Know
* Hearing problems? Yes No Don’t Know
* Speech or vision problems? Yes No Don’t Know
* Childhood diseases such as chicken pox, mumps, measles or Scarlet Fever? ? Yes No Don’t Know
* Tuberculosis? Yes No Don’t Know
* Other medical conditions? Yes No Don’t Know
* Ever had Phen-Fen or Bisphosphorate? Yes No Don’t Know

**DENTAL HISTORY**

**PATIENT INFORMATION**

1. Is this your child’s first visit to the dentist? Yes No Don’t Know
2. If not, how long since the last visit to the dentist?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Were any x-rays taken at that time? Yes No Don’t Know
4. Does your child eat between meals? Yes No Don’t Know
5. Does your child eat sweets/soda? Yes No Don’t Know
6. When does your child brush his/her teeth?

\_\_Upon rising \_\_After eating any food \_\_Right after meals

\_\_Before going to bed

1. Does your child take fluoride? Yes No Don’t Know
2. Has your child ever had any of the following dental problems
3. Injuries to the mouth? Yes No Don’t Know
4. Toothaches or abscesses? Yes No Don’t Know
5. Does your child have any of the following habits?
6. Finger, thumb, or pacifier sucking? Yes No Don’t Know
7. Tooth grinding or clenching Yes No Don’t Know
8. Mouth breathing Yes No Don’t Know
9. Has anyone in the family, including parents had orthodontics? Yes No Don’t Know
10. Has your child ever had sealants? Yes No Don’t Know

**SOCIAL AND BEHAVIOUR HISTORY**

1. Do you think that your child will cooperate for dental treatment? Yes No Don’t Know
2. Has your child had a bad or fearful dental or medical experience? Yes No Don’t Know
3. Has your child had any history of emotional or behavioral problems? Yes No Don’t Know
4. Is your child adopted? Yes No Don’t Know
5. Name and age of siblings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Which of the following best describes your child?
2. \_\_\_\_Advanced in learning process
3. \_\_\_\_Progressively normal
4. \_\_\_\_Slow learner
5. Is there any additional information we should know? Yes No Don’t Know

To the best of my knowledge, the above information is correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian completing form Date Relationship to child