Medical- Dental History

Name_____ Nickname_____ Sex_____

Birthdate_____ Age_____ Child's Physician_____ Date Last Seen_____

Physician's Address_____ Phone (____)_____

1. Are immunizations up to date?_____ Condition of your child's overall health_____
2. Has your child recently undergone or is she/he currently undergoing any medical treatment?_____
3. Has your child ever been hospitalized or had an operation?_____

   _____

4. Does your child have any allergic reactions to any kind of medicine, latex, or food?_____
5. Is your child presently taking any kind of medication?_____ If yes, please list medication and dosage_____

   _____

6. Does your child have any history of : (Please check all that apply)

_____ Allergies	_____ Brain Injury	_____ Autism/ Asperger's
_____ Anemia	_____ Cancer	_____ ADHD
_____ Asthma	_____ Cerebral Palsy	_____ Down Syndrome
_____ Excessive Bleeding	_____ Diabetes	_____ Mental/ Emotional Problems
_____ Hemophilia	_____ Epilepsy/ Seizures	_____ Heart Disease
_____ HIV/ AIDS	_____ Liver Disease/ Hepatitis	_____ Heart Murmur
_____ Sickle Cell Anemia	_____ Kidney Problems	_____ High Blood Pressure
_____ Tuberculosis		_____ Rheumatic Fever

   Other (please specify)_____

7. Has your child ever had any hearing, sight, or speech problems?_____
8. Is there any additional medical information we should know about your child's health?_____

   _____

9. Is this the first time your child has visited a dental office? Yes No

   If not, how long since his/her last visit to the dentist?_____

10. If your child has previously been t the dentist, did he/she receive any of the following:

_____Local anesthetic (Novocaine)	_____X-rays	_____Sedation
_____Nitrous Oxide (Laughing Gas)	_____General Anesthetic	

    Were there any unfavorable reactions?_____

11. Does your child have a history of:

_____ Thumb sucking	_____Tongue thrusting	_____ Lip or nail biting
_____ Pacifier	_____ Mouth breathing	_____ Object biting

12. Has there been any injury to your child's teeth by a fall, blow, bump, or otherwise?_____

_____

13. Up to what age was your child using a bottle at night or breast-feeding?_____
14. Does your child use a sippy cup? Yes No How often?_____
15. How often does your child brush his/her teeth?_____
16. Does your child consume excessive amounts of any of the following:

    _____ Milk _____ Juice _____Candy _____Soda Pop _____Energy drinks

17. Is your child receiving fluoride supplements? Yes No
18. Does your child drink? _____ City water _____Well Water _____Bottled Water _____ Filtered Water
19. Has your child ever complained of:

    ___ Toothache _____Jaw joint sounds or pain

    _____ Teeth sensitive to heat _____ Teeth sensitive to cold

20. Are you concerned about any special dental problems at this time?_____

_____

21. Reason for seeking treatment at this time?_____

_____

22. Do you expect your child to be uncooperative? (if yes, please explain)_____

_____

Consent for Dental Treatment

I request and authorize Dr. Phillips to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Phillips to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Phillips will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.