Medical/Dental History

Reason(s) for visiting our practice _____

Has your child ever been seen by a dentist before?	□ Yes	□No	If yes, Date? _____
Is he/she allergic to anything: (medicine, food)?	□ Yes	□No	If yes, what?_____
Has your child ever been hospitalized?	□ Yes	□No	If yes, what?_____
Is your child taking any medicines at this time?	□ Yes	□No	If yes, what? _____
Are all immunizations current?	□ Yes	□No	
Has he/she ever received sedation/gen anesthesia?	□ Yes	□No	If yes, side effects?_____
Is your child suck his/her thumb, fingers, Pacifier?	□ Yes	□No	
Are your child's teeth brushed twice a day?	□ Yes	□No	

At what age did your child stop bottle/breast feeding? _____
What is your Child's favorite food?_____

Condition of your child's health

	YES	NO		YES	NO
Heart trouble/Rheumatic Fever	□	□	Seizures	□	□
Breathing/Respiratory/Asthma	□	□	Bleeding Disorder	□	□
Liver/Hepatitis/GI problems	□	□	Tuberculosis	□	□
Kidney Problems	□	□	Tumors/Cancer/HIV	□	□
Endocrine System	□	□	Skin disorder	□	□
Neurological Problems	□	□	Diabetes	□	□
Enlarged Tonsil	□	□	Snoring	□	□
Mental Delays	□	□	Physical Delays	□	□
Congenital Birth Defects	□	□	Significant Injuries	□	□
Ear Infections	□	□	Allergies	□	□
Sleep Apnea	□	□			

If yes above, please explain,_____

Other significant medical condition: _____

_____

Signature _____**Relationship**_____**Date**_____

Doctor's Signature _____