



## **CHILD'S DENTAL INFORMATION**

Reason for today's visit: ( ) Exam/Cleaning ( ) Emergency Is your child in pain? ( ) No ( ) Yes How Long? \_\_\_\_\_

Please indicate any of the following problems:

- |                                     |                                 |  |
|-------------------------------------|---------------------------------|--|
| ( ) Lost/Broken fillings            | ( ) Broken or chipped teeth     | ( ) Stained teeth                              |
| ( ) Red, swollen, or bleeding gums  | ( ) Teeth grinding              | ( ) Frequent headaches or earaches             |
| ( ) Sensitive tooth, teeth, or gums | ( ) Ringing in ears             | ( ) Painful, locking, clicking, or popping jaw |
| ( ) Bad breath                      | ( ) Blister's or sores in mouth | ( ) Loose tooth                                |

Does your child require antibiotic pre-medication? ( ) Yes ( ) No

Previous Dentist Name and Phone #: \_\_\_\_\_

Last Dental Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Times a day child brushes? \_\_\_\_\_ Times a week child flosses? \_\_\_\_\_

Is your child's water fluoridated? ( ) Yes ( ) No

How would you rate your child's smile? **Worst** 1 2 3 4 5 6 7 8 9 10 **Best**

## **CHILD'S MEDICAL HISTORY**

Child's Physician: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Date of last medical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Does your child take any medications? ( ) NO or ( ) YES (Please list below)

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

Does your child have any medical conditions we should be aware of? ( ) NO or ( ) YES (Please list below)

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

Is your child allergic to any of the following? ( ) Latex ( ) Penicillin/Amoxicillin ( ) Tetracycline ( ) Sulfa ( ) Aspirin

( ) Dental Anesthetic ( ) Food allergies ( ) Other: \_\_\_\_\_

Please rate your child's general health from 1-10: \_\_\_\_\_ Does your child do any of the following? ( ) Thumb/finger sucking

( ) Tongue thrusting/sucking ( ) Heavy snoring ( ) Mouth breathing ( ) Lip/sucking/biting ( ) Fingernail biting

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE