

PLEASE COMPLETE ENTIRE FORM

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

Child's Physician (Office and Doctor's Name) \_\_\_\_\_

Phone Number of Physician's Office \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Are Immunizations Up to Date?  Yes  No Is Your Child in General Good Health?  Yes  No

Has Your Child Ever Been Hospitalized or Had Any Kind of Surgery?  Yes  No If so, Please explain and give date \_\_\_\_\_

Is Your Child Allergic to any Antibiotics/Drugs?  Yes  No If Yes, Please Explain What and What Type of Reaction \_\_\_\_\_

Is Your Child Allergic to Anything Else (i.e: latex, dyes, etc)?  Yes  No If Yes, Please Explain What and What Type of Reaction \_\_\_\_\_

Please check yes or no if your child has been diagnosed or treated for any of the following:

Table with 8 columns: Condition, YES, NO, Condition, YES, NO, Condition, YES, NO. Rows include Asthma, Heart Disease, Bleeding Disorders, Environmental/Seasonal Allergies, Liver Disease, Anemia, ADHD/ADD, Kidney Disease, Seizures/Epilepsy, Autism Spectrum Disorder, Cancers/Tumors, Diabetes, Down's Syndrome, Personality/Social Disorders, Hepatitis, Cerebral Palsy, Vision Problems, AIDS/HIV, Cleft Lip/Palate, Acid Reflux/GERD, Speech/Hearing Difficulties, Mental Delays, and Eating Disorders.

OTHER (NOT LISTED) \_\_\_\_\_

PLEASE ELABORATE ON ANY MEDICAL INFORMATION MARKED \_\_\_\_\_

Is There Any Significant Family History Of Diseases /Oral Cancers?  Yes  No Explain: \_\_\_\_\_

Is Your Child Currently Taking Any Medications?  Yes  No If Yes, Please Explain Below

Drug Name \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_ Reason \_\_\_\_\_

Drug Name \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_ Reason \_\_\_\_\_

DENTAL HISTORY

Are There Any Specific Concerns/Questions Regarding Your Child's Mouth/ Teeth? \_\_\_\_\_

Has Your Child Ever Suffered Any Injuries to The Mouth or Teeth?  Yes  No If Yes, Please Explain \_\_\_\_\_

Has Your Child Ever Seen a Dentist?  Yes  No If So, Name of Dentist and Date of Last Exam \_\_\_\_\_

Has your child previously had a negative experience at the dentist?  Yes  No If So, Please Explain \_\_\_\_\_

Is There Anything You Can Tell Us To Help "Connect" With Your Child? (i.e: Princesses, Trains, Spiderman, Family dog, etc.) \_\_\_\_\_

Does your child currently do any of the following? (Please check all that apply):

Breast Feed  Bottle Fee  Grind  Thumb/Finger Suck  Use a Pacifier  NONE

What Type of Water Is Present In Your Home?  Filtered Water (from tap or fridge)  Reverse Osmosis  Well Water  Bottled Water

Does Your Child Use Fluoride Toothpaste?  Yes  No Any Other Forms Of Fluoride? (Rinse, Vitamins, etc.) \_\_\_\_\_