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Why did you bring the child to the dentist today?

Has the child ever had a serious / difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ) / TMD)? Yes No

Does the child brush his / her teeth daily? Yes No

Floss his / her teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Last Visit Date: _____

Is the child currently under the care of a physician? Yes No

Describe the child's current health: Good Fair Poor

Please list all prescription / over the counter or supplement drugs that the child is currently taking:

Please list all drugs/materials that the child is allergic to: _____

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Has the child ever had the following medical problems?

- | | |
|-----------------------------|-------------------------------|
| Y N Abnormal Bleeding | Y N Handicaps / Disabilities |
| Y N Allergies to any drugs | Y N Hearing Impairment |
| Y N Any Hospital Stays | Y N Heart Murmur |
| Y N Any Operations | Y N Hemophilia |
| Y N Asthma | Y N Hepatitis |
| Y N Cancer | Y N HIV+ / AIDS |
| Y N Congenital Heart Defect | Y N Kidney / Liver Problems |
| Y N Convulsions / Epilepsy | Y N Rheumatic / Scarlet Fever |
| Y N Diabetes | Y N Tuberculosis (TB) |

Please discuss any medical problems that the child has had:

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Does the child have the following habits?

- | | | |
|---|---|------------------------|
| Y | N | Lip Sucking / Biting |
| Y | N | Nail Biting |
| Y | N | Nursing Bottle Habits |
| Y | N | Thumb / Finger Sucking |

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

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I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____

3. Date: _____ Signature: _____

Comments: _____
