

Dental and Medical Health History

Name _____ Date of Birth _____

Your child's health, as well as any medications which your child takes, can have an interrelationship with the dental care your child receives. Please answer each question completely.

How often does your child brush? _____

How often does your child floss? _____

Does your child:

	Yes	No
Take fluoride supplements	_____	_____
Use pacifier	_____	_____
Suck thumb or finger	_____	_____
Suck or bite lip	_____	_____
Bite or chew nails	_____	_____
Grind teeth	_____	_____
Clench jaws	_____	_____
Gag easily	_____	_____
Was your child breastfed?	_____	_____
Age discontinued _____		
Was your child bottle-fed?	_____	_____
Age discontinued _____		

**Has your child ever had the following?
(please check any that apply below)**

_____ autism _____ anemia

_____ asthma _____ mental disorder

_____ developmental delay _____ brain injury

_____ speech disorder _____ cancer

_____ cerebral palsy _____ tuberculosis

_____ diabetes _____ HIV/AIDS

_____ vision disorder _____ bleeding disorder

_____ congenital heart defect _____ my child is healthy

other _____

If your child had/has any of the above,
please explain: _____

Current medications taken _____

Allergies or adverse reactions to any medications (e.g. penicillin, sulfas) _____

Allergies to any substances (e.g. latex) _____

Previous hospitalizations, surgeries, or serious illnesses, and date _____

Has your child had difficulty with previous dental visits? Y N Please describe _____

Date of last dental visit _____ Child's pediatrician _____

Previous dentist _____ Pediatricians no. _____

Is there anything specific you'd like to discuss with Dr. Chris today? _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners as necessary.

Signature of Parent/Guardian

X _____

Date _____