alliance dentistry™

Child's Dental/Medical History

Patient Name _____ **Date of Birth** _____

Dental History

What is the reason for today's visit? _____
Is this the child's first visit to a dentist? ☐ Yes ☐ No If no, when was the last dental visit?_____
Former dentist, if any? _____ _____ Phone _____
Has the child ever had any dental X-rays? ☐ Yes ☐ No
Has your child ever had any injuries to the mouth, head or teeth? _____
Has your child ever had any problem with dental treatment in the past? _____
Has your child ever had any orthodontic treatment? _____
What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water
Has your child ever received fluoride supplements? ☐ Yes ☐ No If yes, what age? _____
How many times are the child's teeth brushed per day? _____ When? _____
Has the child sucked his or her thumb, fingers, or pacifier? ☐ Yes ☐No Does the habit still exist? _____
Does the child grind his or her teeth? ☐ Yes ☐ No

Medical History

1.) Is your child taking any prescription and/ or over the counter medications? ☐ No ☐ Yes
If yes, please list _____
2.) Is your child allergic to any medications? ☐ No ☐ Yes
If yes, please list _____
3.) Is your child allergic to any foods or materials? ☐ No ☐ Yes
If yes, please list _____
4.) Has your child been hospitalized? ☐ No ☐ Yes
When? _____ Reason? _____

Has your child had any history or ever been diagnosed with any of the following:

☐ Anemia
☐ Allergy/ Hay Fever
☐ Artificial heart valve
☐ Artificial joint/ limb
☐ Asthma
☐ Attention Deficit Disorder
☐ Autism
☐ Behavior/ learning disabilities
☐ Epilepsy/ seizure
☐ Birth defects
☐ Bleeding Disorder
☐ Bone/ joint/ orthopedic problem
☐ Brain injury
☐ Cancer, type _____
☐ Cerebral Palsy
☐ Chemotherapy
☐ Chicken Pox
☐ Chronic sinusitis
☐ Cleft lip/ palate
☐ Diabetes
☐ Digestive disturbances
☐ Eye problems
☐ Fainting
☐ Growth problem
☐ Hearing loss/ aids
☐ Heart murmur
☐ Heart problem
☐ Heart surgery
☐ Hepatitis
☐ HIV+ / AIDS
☐ Hormonal disturbances
☐ Kidney problems
☐ Liver problems
☐ Measles
☐ Mumps
☐ Nervous disorders
☐ Pneumonia
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shunt
☐ Sickle cell anemia
☐ Tetanus
☐ Tuberculosis
☐ Other:
_____
_____

Pediatrician/ Physician Name _____ **Phone** _____

I understand that the above information will be used for my child's dental health. I have answered the questions to the best of my ability. If further information is needed you may contact my child's health care physician for any other information.

Parent Signature_____ **Date**_____