ALICIA L. DWYER D.D.S. P.A.

PATIENT'S NAME___________________________________ _______________ Height: _____ Weight:______

LAST FRST M DATE OF BIRTH

PARENT'S/GUARDIAN'S NAME____

CONTACT #

DENTAL HISTORY- CIRCLE THE APPROPIATE ANSWER

1	Is this your child's first visit to a dentist?	YES	NO	COMMENTS
2	If not, how long since the last visit to the dentist?	YES	NO	
3	Were any x-rays taken when your child previously visit the dentist?	YES	NO	
4	Does your child eat between meals?	YES	NO	
5	Does your child eat sweets, such as candy, soda pop, chewing gum?	YES	NO	
6	When does your child brush his/her teeth? o upon arising o after eating any food o right after meal o before going to bed	YES	NO	
7	How does your child receive fluoride? o community water level ___ ppm o well water level_____ ppm o fluoride drops or tablets o fluoride rinse or gel	YES	NO	
8	Have any cavities been noted in the past?	YES	NO	
9	Were any teeth (baby or permanent) removed by extraction?	YES	NO	
	Was it suggested that the space be maintained?			
	Was an appliance placed?			
10	Have there been any injuries to teeth such as falls, blows, chips, etc.? if so describe	YES	NO	
11	Has your child had any problem with dental treatment in the past?	YES	NO	
12	Has anyone in the family, including parents, had orthodontics?	YES	NO	
13	Has your child ever received a local anesthetic?	YES	NO	
14	Has your child ever had occlusal sealants?	YES	NO	
15	Does your child think there is anything wrong with his/her teeth?	YES	NO	

	MEDICAL HISTORY			
1	Does your child have a health problem?	YES	NO	
2	Is your child under the care of a physician? If yes, since when & why?	YES	NO	
3	Name of physician phone #			
4	Is your child receiving any medication, What	YES	NO	
5	Is your child allergic to penicillin, antibiotics, or other drugs?	YES	NO	
6	Does your child have other allergies?	YES	NO	
7	Has your child had any serious illness? When? What?	YES	NO	
8	Has your child ever had surgery?	YES	NO	
9	Does your child have a heart murmur?	YES	NO	
10	Is surgery contemplated?	YES	NO	
11	Does your child experience severe or prolonged bleeding?	YES	NO	
12	Does your child have AIDS or has he/she tested HIV positive?	YES	NO	
13	Has your child tested positive for hepatitis?	YES	NO	
14	Is your child subject to nervous disorders? o Fainting o Seizures o Dizziness o Behavioral/Learning problems	YES	NO	
15	Does your child have frequent headaches?	YES	NO	
16	Has your child had history of (circle appropriate response) diabetes, heart trouble, asthma, kidney infection ,rheumatic fever, epilepsy, cerebral palsy, liver problems, cancer, infections, speech impairments, hearing loss			

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE____ DATE_______

DENTIST'S SIGNATURE____ DATE_______

CHILD DENTAL MEDICAL HISTORY