

### MEDICAL HISTORY

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Taking any medications?  Yes  No List: \_\_\_\_\_

Allergies to medications?  Yes  No List: \_\_\_\_\_

Any history or difficulty with the following:

- |   |                                      |   |  |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles               |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Mononucleosis         |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy    | <input type="checkbox"/> HIV-Aids         | <input type="checkbox"/> Mumps                 |
| <input type="checkbox"/> Cerebral Palsy   | <input type="checkbox"/> Fainting    | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Rheumatic Fever       |

Other (explain) \_\_\_\_\_

### DENTAL HISTORY

Date of last visit to a dentist? \_\_\_\_\_

Check-up  Emergency  Other (explain) \_\_\_\_\_

Current dental problems? \_\_\_\_\_

Any injuries to mouth, teeth, head? \_\_\_\_\_

Past dental experiences?  Favorable  Unfavorable

Brush teeth daily?  Yes  No How Often? \_\_\_\_\_

Do the gums ever bleed when brushing teeth?  Yes  No  Occasionally

Floss teeth?  Yes  No  Occasionally

Is fluoride taken in any form?  Yes  No How often? \_\_\_\_\_

Do you...

- |                                    |                              |                             |                    |                              |                             |
|------------------------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Bite fingernails?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Clench teeth?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Suck thumb/fingers?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Grind teeth?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chew hard objects? (pencils, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sleep with bottle? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breathe through mouth?             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chew gum often?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have difficulty with speech?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sugarless?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

What do you drink most often during the day? \_\_\_\_\_

With meals?  Yes  No Between meals?  Yes  No Sip frequently?  Yes  No

As a parent how much anxiety do you feel when at the dentist?  Very Much  Moderate  Some

### AUTHORIZATION

I authorize the doctor and staff to take needed x-rays and perform diagnostic procedures and examinations necessary to make a through diagnosis of my child's dental needs.

I understand I will be given the opportunity and am encouraged to ask questions concerning my child's dental condition, contemplated or a alternative treatment, procedures and associated risks.

I authorize the doctor and staff to perform mutually agreed upon treatment and procedures and use medications and anesthetics that may be necessary for proper dental care. I understand any medications used including anesthetics embodies some risk. I further understand that unforeseen conditions can arise during the course of treatment which may call for procedures in addition to, or different from those originally contemplated and I will be informed, whenever possible, prior to these additional or changed procedures

I agree to be responsible for payment for dental services provided in this office from my child, due and payable at the time services are rendered unless specific financial arrangements have been made prior to treatment.

Parent's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_