CHILD DENTAL AND MEDICAL HISTORY

Patients Name _____
Last First M.I. Date of Birth

Parents Name _____
Last First M.I.

DENTAL HISTORY - Circle the appropriate answer

Comments

1. Is this the childs first visit to a dentist?.....yes no
   Reason for todays visit _____
2. If not, how long since last visit?_____
3. Does your child brush their teeth on rising?..... yes no
   When going to bed?.....yes no
4. Do you live in an area without fluoridated drinking water.....yes no
5. Have your childs teeth been treated with fluoride?.....yes no
6. Have any teeth been removed or extracted?.....yes no
   Was it suggested that the space be maintained?.....yes no
   Was an appliance placed?.....yes no
7. Have there been any injuries to teeth, such as falls, blows, chips.....yes no
8. Has your child had any unfavorable dental experiences?.....yes no
9. Has your child ever received local anesthetics?.....yes no
10. Has your child ever had sealants placed?.....yes no
11. Any thumbsucking, cheek, lip or nail biting habits?.....yes no

MEDICAL HISTORY

1. Is your child in good health?..... yes no
2. Is your child under the care of a physician?.....yes no
   If yes, since when and why _____
   _____
3. Name of child's physician?_____
4. Has your child had any serious illness?.....yes no
   When_____ What _____
5. Has your child ever had any surgery?.....yes no
6. Does your child have any allergies?.....yes no
7. Is your child allergic to penicillin, other antibiotics, any other drugs...yes no
   If yes please list _____
8. Is your child taking any medications at this time?.....yes no
   What?_____
9. Has your child had any of the following (circle the appropriate answer)
   diabetes, heart trouble, asthma, kidney problems, rheumatic fever,
   heart murmer, toothache, or ear infection?

CONSENT: I certify he truth of all the information given. I also authorize the release of information for those requiring it for treatment of my child. Furthermore since, _____ is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any dental services can be started and accomplished by Dr. Larry Kopczyk, Dr. Brian Vieth, Dr. Tim Majors and or leagally qualified staff members. Such authorization is hereby granted to administer any treatment, anesthetics, and perform such operations or otherwise manage my child as may be deemed necessary or advisable. I undestand I will be consulted before any treatment is rendered.

Parent/ Guardian's signature_____Date _____