ST MARYS DENTISTRY/ Child's Medical and Dental History

Name _____ _____ _____ Date of Birth ___/___/___
Surname First Name(S) Preference D M Y

Address: _____
Complete mailing address, including PO Box or "911" number.

MEDICAL HISTORY Additional Information

1.	Is the child in good health?	□ Yes	□ No	_____
2.	Is the child under the care of a physician	□ Yes	□ No	_____
	If Yes, since when, and why?	When?_____	Why?_____	
3.	Has the child had any serious illness?	□ Yes	□ No	_____
	If Yes, since when, and why?	When?_____	Why? _____	
4.	Has the child had surgery?	□ Yes	□ No	_____
5.	Is the child subject to bleeding?	□ Yes	□ No	_____
6.	Is the child subject to nervous disorders?	□ Yes	□ No	_____
	Fainting or dizziness?	□ Yes	□ No	_____
7.	Does your child have allergies?	□ Yes	□ No	_____
8.	Is the child allergic to penicillin, antibiotics or other drugs?	□ Yes	□ No	_____
9.	Is the child receiving any medication now?	□ Yes	□ No	_____
	If yes, what? _____			
10.	Does the child have a history of: □ diabetes □ heart trouble □ asthma □ kidney infection			
	□ rheumatic fever □ toothaches □ ear infection			_____

DENTAL HISTORY

1.	Is this the child's first visit to a dentist?	□ Yes	□ No	_____
2.	If not, how long since the child's last visit to the dentist?			_____
3.	Does the child eat between meals?	□ Yes	□ No	_____
4.	Does the child eat candy, chewing gum, drink pop?	□ Yes	□ No	_____
5.	Does the child eat well-balanced meals?	□ Yes	□ No	_____
6.	When does the child brush (his/her) teeth ?			
	In the morning □ Before going to bed □ After meals □			_____
7.	Does the child live in an area with fluoridated water?	□ Yes	□ No	_____
8.	Have the child's teeth been treated with fluoride?	□ Yes	□ No	_____
9.	Have cavities been noticed or treated in the past?	□Yes	□ No	_____
10.	Were any teeth (baby or permanent) removed by extractions?	□ Yes	□ No	_____
	Was it suggested by a dentist that the space be maintained?	□ Yes	□ No	_____
	Was an appliance placed?	□ Yes	□ No	_____
11.	Has the child had any injuries/ chips from falls or blows?	□ Yes	□ No	_____
12.	Has the child had any unfavorable dental experiences?	□ Yes	□ No	_____
13.	How many children are there in your family?			_____
14.	Has anyone in the family (including parents) had orthodontics?	□ Yes	□ No	_____
15.	Has the child ever received a local anesthetic?	□ Yes	□ No	_____
16.	Has the child ever had occlusal sealants?	□ Yes	□ No	_____

□ **I have read and answered all of the questions above, and I certify that the information is complete and correct to the best of my knowledge. I also consent to necessary contact with my/the child's physician for more information.**

□ **I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. I will assume responsibility for all associated fees.**

Patient *(Parent or Guardian)* Signature _____Date: _____