Child Name (Print): _____Date _____

Parent/Guardian: _____Dr Name:_____ Dr Phone:_____

Medical History

1. Does your child have a health problem? _____
2. Is your child under care of a physician? □ yes □ no
   Physician's Name_____
3. Is your child allergic to penicillin, antibiotics, or other drugs? _____
4. Is your child allergic to latex? _____
5. Does your child have any other allergies? _____
6. Has your child any serious illness (what and when)? _____
7. Has your child ever had surgery? _____
8. Does your child have a heart murmur? _____
9. Does your child have a bleeding disorder? _____
10. Has your child been tested positive for hepatitis? _____
11. Does your child have problems with fainting, seizures, dizziness? _____
12. Does your child have frequent headaches? _____
13. Is your child currently taking any medications, if so please list?
    _____
14. Other medical conditions we should be aware of? _____
    _____

Dental History

1. Is this your child's first visit to the dentist? _____
2. How often does your child brush his/her teeth? _____
3. How does your child receive fluoride? □ community water □ fluoride supplement
4. Has your child ever had cavities? _____
5. Has your child ever had his/her teeth extracted? _____
6. Has your child ever had trauma to his/her teeth? _____
7. Has your child ever had problems with dental treatment in the past? If yes, explain:
   _____
8. Has your child been complaining of teeth problems? If yes, please explain:
   _____
9. Is there anything else you would like to discuss with us about your child?
   _____

I certify that the above information is complete and accurate.

Parent/guardian's Signature _____ Date: _____

Dentist's Signature _____ Date: _____