Twelve years old and under

Patient's name_____Date of birth _____

Dental History:

1. Is this your child's first visit to the dentist? ☐ yes ☐ no
2. If not, how long since the last visit to the dentist? _____
3. When was the last time your child's teeth were cleaned? _____
4. Does child brush teeth upon waking in the morning? ☐ yes ☐ no
5. Does child brush teeth before going to bed? ☐ yes ☐ no
6. Does your child excessively eat sweets, such as candy, soda pop, chewing gum? ☐ yes ☐ no
7. Do you live in an area without fluoridated water? ☐ yes ☐ no ☐ don't know
8. Have your child's teeth been treated with fluorides? ☐ yes ☐ no ☐ don't know
9. Have there been any injuries to teeth, such as falls, blows, chips, etc.?
   If so, describe_____
8. Has your child had any unfavorable dental experiences?
   _____
9. Has your child ever received a local anesthetic or any form of anesthetic? ☐ yes ☐ no
10. Has your child ever had occlusal sealants? ☐ yes ☐ no ☐ don't know

Medical History:

Medical Doctor_____
Medical Doctor address and phone number_____
_____

1. Is your child currently taking any medication? If so, what medication and why?_____
   _____
2. Has your child had any serious illness or surgery? ☐ yes ☐ no
   When? _____Why?_____
   _____
3. Has your child ever had any allergic reactions to any anesthetics or dental materials?_____
4. Is your child allergic to antibiotics or any other drugs? ☐ yes ☐ no
5. Does your child have any history of heart murmurs or rheumatic fever? ☐ yes ☐ no
6. Does your child have any diseases, conditions or problems that we need to be aware of? Please explain:
   _____
   _____

Parent or Guardian Signature_____Date_____

Dentist's Signature _____ Date _____