



## Child's Dental Information

Child's Name: \_\_\_\_\_

Reason for today's visit: Exam Emergency Consultation

Is child in pain? Yes No How long? \_\_\_\_\_

Please indicate any of the following problems:

Discomfort, clicking or popping in jaw Lost /Broken fillings Stained teeth Sensitive tooth

Red, swollen or bleeding gums Teeth grinding Locking jaw Ringing in ears Bad breath

Blisters/sores in or around the mouth Broken/chipped tooth Loose tooth

Other \_\_\_\_\_

Does child require pre-medication? Yes No Don't know

Previous Dentist: \_\_\_\_\_

Last Dental exam: \_\_\_/\_\_\_/\_\_\_ Last Dental x-rays? \_\_\_/\_\_\_/\_\_\_

Times a day child brushes? \_\_\_ Times a week child flosses? \_\_\_ Is the child's water fluoridated? Yes No

How would you rate the child's smile 1 2 3 4 5 6 7 8 9 10

### Child's Medical History

Is child taking any of the following medications? Pain killers (including aspirin) Ritalin Stimulants

Blood thinners Tranquilizers Insulin Muscle relaxers Others; \_\_\_\_\_

\_\_\_\_\_  
Physician: \_\_\_\_\_ Phone # \_\_\_\_\_ Child's

Address \_\_\_\_\_

**Does child have or ever had any of the following diseases or medical conditions?**

- |                                      |                                |                          |
|--------------------------------------|--------------------------------|--------------------------|
| Y N Abnormal Bleeding                | Y N Difficulty Breathing       | Y N Leukemia             |
| Y N Anemia                           | Y N Fainting/Seizures/Epilepsy | Y N Organ Problems       |
| Y N Artificial Bones/Joints/Implants | Y N Heart Murmur               | Y N Psychiatric Problems |
| Y N Artificial Heart Valve           | Y N Hemophilia                 | Y N Respiratory Problems |
| Y N Asthma                           | Y N Hepatitis                  | Y N Rheumatic Fever      |
| Y N Cancer/Tumors                    | Y N high/Low Blood Pressure    | Y N Scarlet Fever        |
| Y N Chemotherapy                     | Y N HIV+/AIDS/ARC              | Y N Surgeries/Operations |
| Y N Congenital Heart Defect          | Y N Hyper Active/ADD           | Y N Tonsillitis          |
| Y N Diabetes/Hypoglycemia            | Y N Jaw Problems/TMJ/TMD       | Y N Tuberculosis (TB)    |

Please list any other medical condition(s) child has or ever had: \_\_\_\_\_

\_\_\_\_\_

Is child allergic to :  Latex  Penicillin/Amoxicillin  Tetracycline  Dental Anesthetics (Lidocaine)  Aspirin

Food Allergies  Others \_\_\_\_\_

Please rate the child's general health from 1-10 \_\_\_\_\_ Does child wear contact lenses?  Yes  No

Does this child do any of the following?  Thumb/Finger Sucking  Tongue Thrusting/Sucking  Heavy Snoring

Mouth Breathing  Lip Sucking/Biting

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