AZ KID'S DENTAL

Dental History

Child's Name: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female

How did you hear about us? _____

Does your child have an unusual history of the following:

☐ Nursing/Bottle Habits ☐ Pacifier ☐ Thumb/Finger Sucking ☐ Dental Grinding

MEDICAL HISTORY

Name of Child's Physician: _____ Phone: _____

Is Child taking any medications? ☐ Yes ☐ No If yes, what? _____

Is Child allergic to any of the following medications or substances? ☐ Yes ☐ No

☐ Aspirin ☐ Penicillin ☐ Latex ☐ Foods ☐ Metal/Acrylics ☐ Other: _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

AIDS/HIV ☐ YES ☐ NO	Cerebral Palsy ☐ YES ☐ NO	Growth Problems ☐ YES ☐ NO	Orthopedic Problems ☐ YES ☐ NO
Anemia ☐ YES ☐ NO	Chemotherapy ☐ YES ☐ NO	Heart Murmur/ Heart Problems ☐ YES ☐ NO	Tobacco Use ☐ YES ☐ NO
Asthma/Breathing Problems ☐ YES ☐ NO	Child Abuse ☐ YES ☐ NO	Hepatitis/ Liver Disease ☐ YES ☐ NO	Pregnancy ☐ YES ☐ NO
Autism ☐ YES ☐ NO	Chronic Adenoid/ Tonsil Problems ☐ YES ☐ NO	High Blood Pressure ☐ YES ☐ NO	Ulcers ☐ YES ☐ NO
Arthritis ☐ YES ☐ NO	Cleft Lip/Palate ☐ YES ☐ NO	Bladder Conditions ☐ YES ☐ NO	Diabetes ☐ YES ☐ NO
ADHD ☐ YES ☐ NO	Developmentally Delayed ☐ YES ☐ NO	Kidney Disease ☐ YES ☐ NO	Disabilities/ Special Need ☐ YES ☐ NO
Birth Defects ☐ YES ☐ NO	Drug/Alcohol Use ☐ YES ☐ NO	Leukemia ☐ YES ☐ NO	Speech/Hearing Problems ☐ YES ☐ NO
Brain Injury ☐ YES ☐ NO	Emotional Disturbance ☐ YES ☐ NO	Sickle Cell Anemia ☐ YES ☐ NO	Convulsions/ Seizures ☐ YES ☐ NO
Bruise Easily ☐ YES ☐ NO	Excessive Gagging ☐ YES ☐ NO	Tuberculosis ☐ YES ☐ NO	Tumors/Growth ☐ YES ☐ NO
Bleeding/ Clotting Problems ☐ YES ☐ NO	Fainting/Dizziness ☐ YES ☐ NO	Prosthetic Joints/ Pins ☐ YES ☐ NO	Psychiatric Care ☐ YES ☐ NO
Cancer ☐ YES ☐ NO	Fever Blisters ☐ YES ☐ NO		

If answered "YES" to any of the above, please explain: _____

_____

Parent/ Guardian: _____ Date: _____ Doctor: _____ Date: _____

Parent/ Guardian: _____ Date: _____ (1) Doctor: _____ Date: _____

Parent/ Guardian: _____ Date: _____ (2) Doctor: _____ Date: _____