DECK DENTISTRY | Child's Medical and Dental History

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

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 what? When?_____			What? _____
4.	Has the child had surgery?	☐ Yes	☐ No	_____
5.	Is surgery contemplated?	☐ Yes	☐ No	_____
6.	Is the child subject to bleeding?	☐ Yes	☐ No	_____
7.	Is the child subject to nervous disorders?	☐ Yes	☐ No	_____
	Fainting or dizziness?	☐ Yes	☐ No	_____
8.	Does the child have allergies?	☐ Yes	☐ No	_____
9.	Is the child allergic to penicillin, antibiotics or other drugs?	☐ Yes	☐ No	_____
10.	Is the child receiving any medication now?	☐ Yes	☐ No	_____
	If Yes, What? _____			_____
11.	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.	Does the child brush teeth upon arising?	☐ Yes	☐ No	_____
	When going to bed? ☐ Yes ☐ No Right after meals?	☐ Yes	☐ No	After eating any food ☐ Yes ☐ No
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 extraction?	☐ 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 tooth 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 (include. 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 _____