Tell us about your child age 12 and under

Child's name_____
Child's birth date_____ Nickname_____
School_____ Hobbies_____
Who is accompanying the child today? _____
Relationship to child _____
Reason for today's visit? _____
Last dental visit? _____
Is the child currently in pain? _____
Does the child require antibiotics before dental treatment? _____
Has the child ever had a serious/difficult problem associated with previous dental work? _____
Is the child taking fluoridated supplements? _____
Has the child ever had any pain/tenderness in his/her jaw joints? _____
Does the child brush his/her teeth daily? _____
Floss his/her teeth daily? _____
Has he/she been to an orthodontist?___
Child's Physician _____
Phone # _____ Date of last visit _____
Is the child currently under the care of a physician? _____
Please describe the child's current physical health. Good__ Fair __ Poor __
Please list current medications child is taking _____
_____
List all drug allergies_____
Latex allergy Y__N__
Does/ did the child have any of the following habits?

Breast fed Y__ N__	Nursing bottle habits Y__N__
Chewing on objects Y__ N__	Speech problems Y__N__
Clenching/grinding teeth Y__N__	Thumb/finger sucking Y__N__
Lip sucking/biting Y__N__	Tongue/cheek biting Y__N__
Mouth breather Y__N__	Tongue Thrust Y__N__
Nail biting Y__N__	Used pacifier Y__N__

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strictest confidence.
I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of parent or guardian date