Sunridge DENTAL CARE — Child Health/Dental Information

OUR STAFF TAKES YOUR CHILD'S ORAL HEALTH VERY SERIOUSLY. WE NEED SOME BRIEF INFORMATION ON THEIR MEDICAL HISTORY AS IT MAY AFFECT TREATMENT.

ALL INFORMATION IS CONFIDENTIAL.

PERSONAL INFORMATION

Patient's Name — Last / First / Initial | Nickname | Date of Birth | Sex M ☐ F ☐

Parent's/Guardian's Name | Relationship to Patient | Parent's/Guardian's Cell Phone # ( )

Address — PO or Mailing Address | City | State | Zip Code

Parent's/Guardian's Email Address:

DENTAL HISTORY

Is this the child's first visit to a dentist? Yes ☐ No ☐ If no, what was the date of the last dental visit?

Has the child had any problem with dental treatment in the past?

What type of water does your child drink? ☐ City/Filtered ☐ Well ☐ Bottled

Is fluoride toothpaste used? Yes ☐ No ☐

How many times are the child's teeth brushed per day?

When are the teeth brushed?

Has the child:	Yes	No	Does the child:	Yes	No
Had any problem with dental treatment in the past?	☐	☐	Suck their thumb, fingers or pacifier?	☐	☐
Ever suffered any injuries to the mouth, head or teeth?	☐	☐	Clench or grind their teeth?	☐	☐
Had any problems with the eruption or shedding of teeth?	☐	☐	Pain or tenderness in their jaw joint?	☐	☐
Had any orthodontic treatment (braces)?	☐	☐	Participate in active recreational activities?	☐	☐

List any medications that the child is taking including non-prescription drugs including herbals/vitamins:

1._____ 2. _____ 3._____ 4. _____

5._____ 6. _____ 7._____ 8. _____

ALLERGIES- Are you allergic to or have you had a reaction to:	Yes	No		Yes	No
Local anesthetics	☐	☐	Latex (rubber)	☐	☐
Penicillin or other antibiotics	☐	☐	Metals	☐	☐
Codeine or other narcotics	☐	☐	Food	☐	☐
Aspirin	☐	☐	Hay fever/seasonal	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	Other	☐	☐

MEDICAL HISTORY- Does the child have or ever had any of the following conditions?

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Murmur	☐	☐	Diabetes	☐	☐	Hearing Impairment	☐	☐	Rheumatic Fever	☐	☐
Congenital Heart Defect	☐	☐	Abnormal Bleeding	☐	☐	Physical or Mental Impairment	☐	☐	Other disease or illness?	☐	☐
Convulsions/Epilepsy	☐	☐	Kidney/Liver Problems	☐	☐	Cancer	☐	☐			
Asthma	☐	☐	Hepatitis	☐	☐	Any Operations	☐	☐			

Women

Is or could the child be pregnant or nursing? ☐ ☐ Is the child taking any birth control prescriptions? ☐ ☐

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician regarding additional birth control methods.

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in the child's health and/or medication. **I also authorize the dental staff to perform the necessary dental services my child may need.**

Parent/Guardian signature:_____Date:_____

Medical History Update

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____

Date _____ Comments _____ Signature _____