



Child's Name: \_\_\_\_\_ What does your child like to be called? \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female Grade Level: \_\_\_\_\_ School: \_\_\_\_\_  
 Child's Physician: \_\_\_\_\_ Approximate Date of Last Physical Exam: \_\_\_\_\_  
 Patient's Hobbies, Interests, Pets, etc.: \_\_\_\_\_  
 Other children and their ages: \_\_\_\_\_  
 Reason for visiting our office today: Checkup Decay Habit Orthodontics Emergency Other  
 Orthodontic Concerns: \_\_\_\_\_

- YES NO Is your child under the care of a physician for other than routine care?**  
 If yes, please explain: \_\_\_\_\_
- YES NO Does your child have a heart murmur, artificial heart valve, prosthetic joint, or any other foreign materials/objects?**  
 If yes, please circle which one. If your child has a heart murmur, who diagnosed it? \_\_\_\_\_
- YES NO Does your child have any drug allergies or has your child ever had a reaction to a drug?**  
 If yes, please list the drug(s) and the reaction(s): \_\_\_\_\_
- YES NO Does your child take any medication on a regular basis?**  
 If yes, please list: \_\_\_\_\_
- YES NO Is your child taking any medication at this time that he/she does not normally take on a regular basis?**  
 If yes, please explain: \_\_\_\_\_
- YES NO Has your child EVER been a patient in a hospital?**  
 If yes, please explain: \_\_\_\_\_
- YES NO Has your child EVER been seen in an emergency room for ANY reason?**  
 If yes, please explain: \_\_\_\_\_
- YES NO Does your child have or does anyone in your family have a condition called methylenetetrahydrofolate reductase deficiency (MTHFR) or hyperhomocysteinemia?**
- YES NO Does your child have any known allergy to nickel? If yes, describe allergy:** \_\_\_\_\_

**Please circle any condition your child currently has or has ever had:**

Adrenal Disorder	Ear/Eye Disorder	Liver Disease	Intellectual Impairment	Hepatitis
Hearing Problem	Allergy	Muscle Disorder	Behavior Issue	Asthma
Intestinal Problem	Congenital Birth Problem	Nose/Throat Disorder	Speech Issue	Autism
Abnormal Bleeding	Heart Condition	Seizures	Kidney Problem	ADD/ADHD
Blood Disease	Endocrine Problem	Skin Disorder	Physical Impairment	Asperger's
Bone Disorder	HIV/AIDS	Cancer	Stomach Problem	Sensory Issues
Brain Disorder	Learning Difficulty	Tumor	Breathing Problem	
	Lung Disorder	Diabetes		

- YES NO Has your child ever seen a pediatric dentist before? If yes, approximate date of last exam:** \_\_\_\_\_
- YES NO Has your child ever been seen by a regular general dentist before? If yes, approximate date of last exam:** \_\_\_\_\_
- YES NO Do you expect your child to be uncooperative?**
- YES NO Does your child drink unfluoridated water?**
- YES NO Does your child take fluoride tablets, fluoride drops, or vitamins which contain fluoride?**
- YES NO Has your child ever bumped any teeth? If so, when:** \_\_\_\_\_
- YES NO Has your child ever experienced facial pain or had problems with the jaw joints near each ear?**
- YES NO Is your child a "toothpaste eater"?**
- YES NO Has your child had a traumatic medical or dental experience? If yes, please explain:** \_\_\_\_\_
- YES NO Does your child suck his/her thumb, finger(s), pacifier, blanket, something else? If yes, what:** \_\_\_\_\_
- YES NO Does your child have difficulty breathing through the nose with his/her mouth closed?**
- YES NO Is there anything else you would like us to know or that we need to know about your child?**  
 If yes, please explain: \_\_\_\_\_
- YES NO Young Children Only: Does your child have a bottle to go to sleep?**

**THE ABOVE MEDICAL DENTAL AND MEDICATION HISTORY IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGE IN THE ABOVE PRIOR TO ANY APPOINTMENT.**

**Signed (Parent/Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print (Parent/Guardian):** \_\_\_\_\_