Medical and Dental Information

Thank you for answering these important questions. They are of great value in aiding us to a better understanding of your child.

Patient Name _____ Today's Date: _____

11. Dental History

Is this your child's first visit to the dentist? YES NO

If not, name of previous dentist: _____

Date of last visit: _____ Were x-rays taken? Y N

What is your primary reason for seeking dental care with our office today? _____

Has your child complained of any dental problems?

_____

Have there been any injuries to the teeth, face or mouth?

No Yes _____

Has your child ever had any of the following? If yes, circle:

dental cavities toothaches abscesses

cold sores ulcers bad breath

Does your child have any of the following habits?

thumb/finger sucking pacifier nail biting

sippy cup use nursing/bottle habits grinding teeth

Has your child ever had a negative experience associated with previous dental work? Yes No

If yes, please explain: _____

In your family is there any history of malocclusions, bad bites, missing or extra teeth? _____

Does your child brush daily? Yes No

Do you assist? Yes No Is floss used? Yes No

Does your child drink: City Water Well Water

Bottled Water Filtered Water

Does your child have a dental condition which concerns you? _____

12. Medical History

Please indicate with a (X) any condition(s) your child has or has had:

___ Abnormal Bleeding
___ ADHD
___ Anemia
___ Allergies to Drugs
___ Allergies/Hay Fever
___ Any Hospital Stays
___ Any Operations
___ Asperger's Syndrome
___ Asthma
___ Autism
___ Blood Transfusion
___ Brain Injury
___ Cancer
___ Cerebral Palsy
___ Cleft Lip/Palate
___ Congenital Birth Defects
___ Diabetes
___ Downs Syndrome
___ Ear Disorders/Tubes
___ Emotional Disturbance
___ Epilepsy/Seizures
___ Eye Problems
___ Fainting
___ Handicaps/Disabilities
___ Hearing Loss
___ Heart Condition
___ Heart Murmur
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ HIV/AIDS
___ Integrated Sensory Dis.
___ Kidney/Liver Disorder
___ Latex Allergy
___ Mental Retardation
___ Orthopedic Problems
___ Scoliosis
___ Sickle Cell Anemia
___ Speech Problems
___ Spinal Bifida
___ Stomach Problems
___ Other

Please explain any (X) above and/or note any special information about your child's health we should know: _____

_____

___ *My child has never been diagnosed as having any of the above medical conditions.*

Child's current medications: _____

Please list all drugs your child is allergic to: _____

Child's Physician: _____

I certify that I have read and understand the above questions. I will not hold Dr. Turner, Associates, or any member of her staff responsible for any errors or omissions I may have made when completing this form. I authorize the doctors and staff of this office to provide any examinations, x-rays and procedures to diagnose oral and dental disease, and to provide after explanation, all forms of treatment, medications, and therapy indicated for the dental care of the above named child.

Signature of Parent or Legal Guardian _____ Date _____