PLEASE FILL OUT ONE FORM FOR EACH CHILD

Patient Name (Last, First, Middle)	Nickname/Answers to:	Date of Birth:	Age: _____ yrs _____mon.	Sex: ❑ Male ❑ _____ ❑ Female

Please list any current medications:	Any Drug/Food Allergies? ❑ No ❑ Yes (explain)	Are your child's immunizations current? ❑ Yes ❑ No If No, do you have a delayed plan with your pediatrician (explain):_____

Has your child ever had a health problem ❑ No ❑ Yes If yes, please explain:	Has your child ever been hospitalized, had general anesthesia or an emergency room visit? ❑ No ❑ Yes (please explain):

PLEASE CHECK OFF IF YOUR CHILD HAS BEEN TREATED FOR ANY OF THE FOLLOWING:

_____ Abuse	_____ Cleft Lip/ Palate	_____ Infectious Disease	_____ Recurrent Headaches	_____ Tonsil/ Adenoid Issues
_____ ADHD/ADD	_____ Congenital Birth Defects	_____ Kidney Disease	_____ Respiratory Issues	_____ Thyroid Disease
_____ AIDS/HIV	_____ Diabetes		_____ Rheumatic Fever	_____ Tuberculosis
_____ Anemia	_____ Endocrine/ Growth Issues	_____ Liver Disease/ GI Disease	_____ Seasonal Allergies	_____ Tumors/ Growths
_____ Asthma	_____ Frequent Infections		_____ Seizures/Epilepsy	_____ Visually Impaired
_____ Autism	_____ Hearing Impaired	_____ Mental Delays	_____ Shunts	Other/explain:
_____ Blood Dyscrasias	_____ Heart Disease	_____ Personality/ Social Disorders	_____ Sickle Cell Disease/ Trait	
_____ Bone Disease	_____ Heart Murmur	_____ Pregnant	_____ Sleep Apnea	
_____ Cancer	_____ Heart Surgery	_____ Premature delivery	_____ Speech Issues	
_____ Cerebral Palsy	_____ Hepatitis	_____ Radiation Treatment	_____ Spina Bifida	

DENTAL HISTORY

What is the reason for your child's visit today?
_____

Has your child ever been to the dentist? ❑ Yes ❑ No
Date of last cleaning & x-rays_____

Name/Location of previous dentist/ office: _____

Has your child had local anesthetic? ❑ Yes ❑ No

Has your child experienced any unfavorable reaction from previous dental care? ❑Yes ❑ No _____

Has your child been sedated for dental treatment? ❑ Yes ❑ No
_____

Have your child's teeth ever been injured? ❑ Yes ❑ No
_____

Does your child suck a finger, thumb or pacifier? ❑ Yes ❑ No
_____

Does/did your child go to bed with a bottle/sippy cup? ❑ Yes ❑ No
_____

Does your child smoke/chew/vape tobacco? ❑ Yes ❑ No
_____

Please circle if your child is having problems with any of the following:

Cavities	Toothache	Sensitivity	Mouth Breathing	Trauma
Color of Teeth	Orthodontics	Jaw Sounds	Grinding	Gum Infections

FLUORIDE HISTORY

Is your home water supply fluoridated? ❑ Yes ❑ No

Do you use well water at your residence? ❑ Yes ❑ No

Does your child use fluoridated toothpaste? ❑ Yes ❑ No

Do you give your child any other forms of fluoride? ❑ Yes ❑ No

_____

Does your child participate in a school fluoride program? ❑ Yes ❑ No

TONGUE-TIE / LIP-TIE

Does/did the child have any issues with **BREASTFEEDING** - Issues can include poor latch, incomplete feeding, clicks/pops during feeding, weight loss, or painful breastfeeding.

❑ Yes ❑ No ❑ Did not breastfeed

Does/did the child have any issues with **EATING/GAGGING** – Issues can include slow eating, picky about foods or textures, gagging/vomiting during/or after meals, gassiness/stomachaches

❑ Yes ❑ No

Does/did your child have any issues with **SPEECH** – Issues can include delayed speech, poor pronunciation, mumbling/talking softly, not meeting speech milestones?

❑ Yes ❑ No ❑ My child is under 2y old

❑ Yes ❑ No Has anyone said your child has a lip or tongue tie?
❑ Yes ❑ No Has your child had a lip/tongue tie correction?