



Dentistry For Children

Biographical Data (Filled in by parent of guardian)

Name _____ Birthdate _____ Sex _____

Social Security Number of Patient _____ Home phone _____

Home Address _____ City _____ Zip _____

Other Children in Family _____

Pets, Hobbies _____

Father's Name _____ Birthdate _____ Marital Status S M W Se

Social Security Number _____ Email Address _____

Occupation _____ Employer _____ Phone _____

Mother's Name _____ Birthdate _____ Marital Status S M W Se

Social Security Number _____ Email Address _____

Occupation _____ Employer _____ Phone _____

Legal Guardian/ Step Parent/ Grandparent _____

Social Security Number _____ Birthdate _____

Occupation _____ Employer _____ Phone _____

Email address _____

To be notified in emergency _____ Phone _____

Dental care to be paid by: Cash _____ Charge card _____ Dental carrier _____

Person responsible for this account _____ Driver's License No. _____

Address _____ Phone _____

What is the main reason for the visit today? _____

Who may we thank for your referral? _____

Dental History

1. Is this your child's first visit to a dentist? Yes _____ No _____

2. If no, give date of last examination _____ Dentist's name _____
Where x-rays taken? Yes _____ No _____
3. Has your child recently had any of the following?
Tooth abscess (gum boil) _____ Frequent sore throats _____ Bad breath _____
Cold sores _____ Clicking, popping or pain in the jaw _____ Stained teeth _____
Injury to teeth _____ Toothache _____ Bleeding gums _____
4. Does your child have habits which might affect oral health? If yes, check.
Finger or thumb habits _____ Use of bottle _____ Use of pacifier _____ Other _____
5. Is your child presently nursing or drinking from a bottle? Yes _____ No _____
If no, when did they stop? _____ Liquid in bottle _____
When was this used? Nap time _____ nighttime _____ daytime _____ Number of bottles/day _____
6. Does your child use a prescription Fluoride gel or vitamin? Yes _____ No _____
A Fluoride rinse? Yes _____ No _____

Medical History (Please answer all the questions)

1. Does your child have any health problems? Yes _____ No _____
If yes, explain _____
2. Were difficulties encountered during pregnancy or delivery of this child? Yes _____ No _____
If yes, explain _____
3. Did your child have a history of health problems at birth or during initial years. Yes _____ No _____
If yes, explain which years _____
4. Is your child taking any medications or drugs at this time? Yes _____ No _____
Please list _____
5. Does your child have an allergy or bad reaction to Penicillin? Yes _____ No _____
Does your child have an allergy to codeine? Yes _____ No _____
Any other medications? Please list _____
6. Has your child ever been hospitalized or seriously injured? Yes _____ No _____
Date and reason _____
7. Has your child had any history of the following?
AIDS _____ Diabetes _____ Hemophilia or Other _____ Mental/emotional Problems _____
Allergies _____ Drug reactions _____ Bleeding Problems _____ Recurrent Headaches _____
Blood Disorders _____ Endocrine system _____ Hepatitis _____ Rheumatic Fever _____
Blood transfusion _____ GI problems _____ HIV positive _____ Seizures _____
Breathing or Lung Problem _____ Growth Problem _____ Infection _____ Sight _____
Cancer/Tumor _____ Hearing _____ Kidney/Liver problems _____ Sickle Cell Anemia _____
Congenital birth defects _____ Heart Trouble or Murmur _____ Malignant Hyperthermia _____
TMD Hx _____ Other _____
Comments _____
8. Date and reason of last medical examination _____
9. Is your child emotionally or physically handicapped or do they have problems with:

Concentrating _____ Learning _____ Speech _____ Cooperating _____ Understanding _____

If so, describe _____

10. Has your child had any physically or emotionally traumatic experiences that you feel would be helpful for us to know about?

11. Is there additional information or comments we should know? _____

12. Name of pediatrician or family physician _____

Address _____ Phone _____

Last physical examination date _____

Signature (parent or guardian) _____ Date _____

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