CEDAR ISLAND DENTAL MEDICAL AND DENTAL INFORMATION (Child)

Patient's Name: _____ Birth date: ___/___/___ Date: ___/___/____

DENTAL HISTORY

Is this the first dental visit? Yes □ No □ If no, how long since last visit? _____

Were x-rays taken? Yes □ No □ Is your water fluoridated or is your child taking fluoride supplements? Yes □ No □

When does your child brush and floss? _____ Alone or with assistance? _____

Does your child use a pacifier or suck his/her thumb? Yes □ No □

Have there been any injuries to the teeth or face? Yes □ No □

Does your child eat/drink sweets such as candy, pop, or chewing gum? Yes □ No □

Has your child ever received local anesthetic (Novocaine)? Yes □ No □

Have sealants been placed? Yes □ No □

MEDICAL HISTORY

Physician's Name: _____ Phone Number: _____ Date of Last Visit: ___/___/__

Is your child under the care of a physician or have any health problem? Yes □ No □ If yes, explain: _____

_____

_____

Please list any prescription and over-the-counter medications your child takes: _____

_____

_____

Please check any of the following that apply to you now or in the past:

Abnormal bleeding	___	Convulsions/epilepsy	___	HIV/AIDS	___
ADD/ADHD	___	Diabetes	___	Rheumatic/Scarlet fever	___
Allergies to any drugs	___	Disabilities	___	Serious illness/injury	___
Artificial joints/valves	___	Hearing impairment	___	Sickle cell disease	___
Asthma	___	Heart murmur	___	Surgeries	___
Cancer	___	Hemophilia	___	Tuberculosis	___
Congenital heart defect	___	Hepatitis	___		

Does your child have any known allergies to medications, latex, or other? Yes □ No □

If yes, please list: _____

_____

I certify the above information is complete and accurate. It is my responsibility to inform this office of any changes in my child's medical history.

_____ _____

Patient's/Guardian's signature Date