Dr. Doug McDermid, DMD
Dr. Rose Dhillon, DMD

CHILD DENTAL MEDICAL HISTORY

Patient Information | (Please Print)

PATIENTS First name Last name Middle Initial D.O.B

PARENTS First name Last name Middle Initial

DENTAL HISTORY

CIRCLE THE APPROPRIATE ANSWER

1. Is this the childs first visit to the Dentist?	YES	NO
2. If not, how long ago was the child last visit?	YES	NO
3. Does your child eat between meals?	YES	NO
4. Does your child eat sweets ie: soda pop, candy or chewing gum?	YES	NO
5. Does your child eat well balanced meals?	YES	NO
6. Does your child brush teeth upon arising?	YES	NO
II) When going to bed?	YES	NO
III) Right after eating meals?	YES	NO
IIII) After eating any food?	YES	NO
7. Do you live in an area without fluoridated water?	YES	NO
8. Have your teeth ever been treated with fluoride?	YES	NO
9. Have any cavities been noted in the past?	YES	NO
10. Were any teeth (baby or permanent) removed by extraction?	YES	NO
II) Was it suggested that the space be maintained?	YES	NO
III) Was an appliance placed?	YES	NO
11. Have there been any injuries to teeth ie: falls, chips etc…?	YES	NO

If so please describe: _____

12. Had your child had any unfavorable dental experiences?	YES	NO
13. How many children are in your family? _____		
14. Has anyone in the family, including parents, had orthodontics (braces)	YES	NO
15. Has your child ever received local anesthetic?	YES	NO
16. Has your child ever had occlusal sealants?	YES	NO

MEDICAL HISTORY

CIRCLE THE APPROPRIATE ANSWER

1. Is your child in good health?	YES	NO
2. Is your child under the care of a physician?	YES	NO

II) If yes, for how long and why? _____

3. Name of physician? _____

4. Has your child had any serious illnesses?	YES	NO

When? _____ Why? _____

5. Has your child had surgery?	YES	NO
6. Is surgery contemplated?	YES	NO
7. Is child subject to profuse bleeding?	YES	NO
8. Is your child subject to nervous disorders?	YES	NO
Fainting?	YES	NO
Dizziness?	YES	NO
9. Does your child have allergies?	YES	NO
10. Is your child allergic to penicillin, or another antibiotics or drugs?	YES	NO
11. Is child receiving any medication?	YES	NO

12. Has child had a history of: (circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection?

I CERTIFY THAT THE ABOVE INFORMTION IS COMPLETE AND ACCURATE

I understand that an electronic copy of my signature and the information I have provided will be created. This electronic copy will serve as a genuine copy of my original signature and may be used in place of original for any purpose.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

Witness _____