

1. Specific dental concerns you would like us to address: _____
- Y N 2. First dental visit? If no, when was the last visit & with whom? _____
3. When does your child brush his/her teeth?
 Morning Between Meals Bedtime
- Y N 6. Do you supervise the brushing?
- Y N 7. Does your child floss?
8. What type of water sources do you use? City Well Bottled Other _____
9. Does your child consume any of the following on a daily basis: (check all that apply)
 Soda Chocolate/Strawberry Milk Juice Sweet Tea Chips Crackers/Dry Cereal Candy/Gum
- Y N 10. Does your child suck a thumb or finger, use a pacifier, chew on fingernails or other materials? _____

For preschool children:

Y N 4. Does your child currently use a bottle or breast feed?

At what age did the child stop? _____ mos.

Y N 5. Does your child use a sippy cup between meals or at night?

11. Name of child's pediatrician/physician: _____ Phone # _____
- Y N 12. Is your child currently under the care of a physician? Date of Last Physical (Month/Year) _____
 If yes, please explain: _____
- Y N 13. Are your child's vaccinations current?
- Y N 14. Does your child take any medication? Please list with dosage and frequency: _____

- Y N 15. Does your child have any allergies to medications, food, latex, or other materials?
 Please list: _____
- Y N 16. Has your child ever been admitted to a hospital, had surgery, or had a serious illness or injury?
 Please list the date and reason: _____

Does your child have a history of any of the following (circle all that apply) :

- Y N 17. Heart murmur or heart disease _____
- Y N 18. Respiratory problems (asthma, reactive airway disease, tuberculosis, etc.) _____
- Y N 19. Neurological disorders (epilepsy, seizures, cerebral palsy, shunts, ADD, etc.) _____
- Y N 20. Sight, hearing, or speech problems _____
- Y N 21. Bleeding disorders, anemia, transfusions, HIV, etc. _____
- Y N 22. Diabetes, lupus, arthritis, or auto-immune diseases _____
- Y N 23. Premature birth (by how many weeks _____) _____
- Y N 24. Liver disease, hepatitis, or jaundice _____
- Y N 25. Kidney, stomach, or gastrointestinal disorders _____
- Y N 26. Skin, bone, or muscle disorders _____
- Y N 27. Leukemia, cancer, or tumors _____
28. Is there anything else we should know while treating your child? _____

X _____
 Signature

 Date

 Your Relationship to the Child

Staff Notes:
