Hollywood Children's Dentistry

Medical/Dental History

Child's Name_____
Preferred Name/Nickname_____
Birth Date_____ **Age**_____ **Sex**_____ **Weight**_____
Child's Physician _____

Dental History

Has your child been to the dentist before? Yes No
Were x-rays taken? Yes No Date_____
Dentist's name _____
Address_____
_____
Phone_____
Comments_____

How would you expect your child to behave in our office? _____
(Ex: shy, enthusiastic, curious, nervous, cautious)
Is your child nervous about this visit? Yes No
Is there fluoride in your drinking water? Yes No
Does your child take a fluoride supplement? Yes No
If yes, what: _____ Who prescribed: _____
Does your child brush his/her own teeth? Yes No
Do you help your child brush? Yes No
Does your child use dental floss? Yes No
Has your child ever had a toothache? Yes No
Has your child injured their teeth? Yes No
If yes, explain: _____
Is there a history of tooth decay in the family? Yes No
If yes, explain: _____
Does (or did) your child have any of the following habits? (please check)

___Clenching or grinding teeth ___Finger or thumb habit
___Mouth breathing ___Pacifier
___Speech problems ___Feeding difficulties
___Snoring Other: _____

Diet History

How many meals does your child eat per day? _____
How many snacks does your child eat per day?_____
List three of your child's favorite snacks:_____
Was your child breast fed? Yes No Age stopped:_____
Was your child bottle fed? Yes No Age stopped:_____
If bottle fed, the bottle usually contained: _____
Was your child allowed to fall asleep with bottle? Yes No
Were teeth cleaned after naptime/nighttime feedings? Yes No

Child's Name_____

Medical History

Is your child in good health?	Yes	No
Is your child sensitive/allergic to latex?	Yes	No
Does your child bruise easily?	Yes	No
Does your child bleed excessively when cut?	Yes	No
Was your child ever hospitalized or had surgery?	Yes	No

If yes, when:_____ Why:_____

Does your child have (or had) any of the following conditions:

Cancer	Yes	No
ADD/ADHD	Yes	No
Developmental disability	Yes	No
Cerebral Palsy	Yes	No
Seizures	Yes	No
Sleep Apnea	Yes	No
Anemia	Yes	No
Allergies	Yes	No
Asthma (or Reactive Airway Disease)	Yes	No
Diabetes	Yes	No
Digestive disorders	Yes	No
Gastroesophageal Reflux Disease	Yes	No
Heart disease or defects	Yes	No
Liver disease	Yes	No
Kidney disease	Yes	No
Tuberculosis (or exposure)	Yes	No
Hepatitis A, B or C	Yes	No
AIDS/HIV positive	Yes	No
Auto Immune disorder	Yes	No
Blood disorder	Yes	No
Hearing difficulty	Yes	No
Frequent colds	Yes	No
Frequent ear infections	Yes	No
Pregnant	Yes	No

Any other condition not listed above: _____

List current medications and reason: _____

_____

List medications allergic/sensitive to: _____

List food allergic/sensitive to: _____

Additional Comments or Remarks: _____

_____

The signature of the parent/guardian below authorizes Dr. Sheena Kansal or staff to perform a dental exam, dental cleaning, fluoride treatment and obtain dental x-rays on the above named child.

_____ _____ _____

Signature Relation to patient Date