



HEALTH INFORMATION Ages 6-12 years

Patient Name: _____ Date of Birth: _____ Today's Date: _____

DENTAL HISTORY

How often does your child brush their teeth? _____ What toothpaste do they use? _____

Does your child use any fluoride supplements? Yes No Describe: _____

Does your child floss daily? Yes No Does an adult assist with the brushing and/or flossing? Yes No

Does your child drink juices/sweetened drinks? Yes No If yes, what kind: _____

On average, how many times per day does your child snack in between meals? _____

Does your child have any of the following habits? If yes, please check Past or Current:

Pacifier	P/C	Cheek Biting	P/C	Lip Sucking	P/C	Jaw Clenching	P/C	Snoring	P/C
Thumb Sucking	<input type="checkbox"/> <input type="checkbox"/>	Nail Biting	<input type="checkbox"/> <input type="checkbox"/>	Tongue Thrust	<input type="checkbox"/> <input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/> <input type="checkbox"/>	Grinding	<input type="checkbox"/> <input type="checkbox"/>

Does your child participate in contact sports? Please list: _____

Has your child had any injuries to teeth, mouth, face, or head? If yes, please describe: _____

Is there clicking, popping, or discomfort in the jaw joints? Yes No If yes, when did it begin: _____

How do you think your child will react to dental treatment? _____

MEDICAL HISTORY

Current Age: _____ Height: _____ Weight: _____ Pronouns: _____

Is your child taking any medications or drugs? Yes No If yes, list: _____

Is your child sensitive or allergic to any drug(s), food(s), latex products, or other materials? Yes No

If yes, describe: _____

Has your child ever been hospitalized or had a major operation? Yes No If yes, describe: _____

Are your child's immunizations up to date? Yes No If no, reason: _____

Child's Pediatrician: _____ Date of Last Visit: _____

Pediatrician Location/Address: _____ Phone #: _____

MEDICAL HISTORY

Has your child ever been diagnosed as having any of the following? If yes, please select:

- | | | |
|---|--|--|
| <input type="checkbox"/> ADD and/or ADHD | <input type="checkbox"/> Congenital Disorders | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> AIDS and/or HIV+ | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> High / Low Blood Pressure |
| <input type="checkbox"/> Artificial Joints or Limbs | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Asthma / Breathing Problems | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Diabetes Type 1 or Type 2 | <input type="checkbox"/> Nutritional Deficiency |
| <input type="checkbox"/> Bone Conditions | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Oral Ulcers |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Cancer or Malignancies | <input type="checkbox"/> Endocrine Conditions | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Conditions | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemotherapy / Radiation | <input type="checkbox"/> Excessive Gagging | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Chronic Adenoid/Tonsil Infection | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Gastrointestinal Issues | <input type="checkbox"/> Speech Impediment |
| <input type="checkbox"/> Chronic Headaches or Migraines | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Cleft Lip / Palate | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Tuberculosis |

Any Other Dental or Health Concerns: _____

To the best of my knowledge, the questions on this form have been answered with accuracy. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in health.

Parent/Guardian Name (Print): _____ Signature: _____

CLINICAL USE ONLY

Reviewed by: _____