DENTAL HISTORY

Patient's Name_____ **Date**_____

Reason for today's visit_____

Is this your child's first dental visit? ___YES ___NO If no, date of last visit_____

How often does your child brush?_____

Please list all allergies_____

Please list all medications they are currently taking _____

Is your child in good health?..... ( ) YES ( ) NO
If NO, please describe_____
Does your child have regular medical exams?.....( ) YES ( ) NO
Is your child up to date on immunizations?.....( ) YES ( ) NO
Is your child a thumbsucker?.....( ) YES ( ) NO
Does your child use a pacifier?.....( ) YES ( ) NO
If your child was bottle fed, at what age was it discontinued?_____
Has your child experienced any bad reaction to medications?.....( ) YES ( ) NO
If yes, please list_____
Has your child been hospitalized since birth?.....( ) YES ( ) NO
If yes: Date_____ **Reason**_____
Has your child ever had an unfavorable experience at the dentist?.....( ) YES ( ) NO
Does your child have a toothache?.....( ) YES ( ) NO
If yes:_____
Where **How Long?**

Does your child have a history of the following?

( ) Asthma	( ) Hearing Disorder	( ) Vision Disorder	( ) Sickle Cell Anemia
( ) Allergies	( ) Heart Condition	( ) Nerve Disorder	( ) Pregnancy--Teens
( ) Autism	( ) Hepatitis	( ) Kidney Disease	( ) Thyroid
( ) Bleeding Disorder	( ) HIV/AIDS	( ) Liver Disease	( ) Epilepsy
( ) Brain Injury	( ) Heat/Sun stroke	( ) Speech Disorders	
( ) Cerebral Palsy	( ) Heat Exhaustion	( ) Lung Disease	
( ) Convulsions	( ) Heart Problems	( ) Rheumatic Fever	
( ) Diabetes	( ) Downs Syndrome	( ) Mental Disorder	

OTHER:_____

EMERGENCY CONTACT:_____ **PHONE**_____

The information contained on this form is correct to the best of my knowledge. I will not hold this dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the use of photographs/videos for lectures or publications by Dr. David Hippensteel and Staff as an example of treatments performed **___YES ___NO**.

SIGNATURE (Patient/Parent/Guardian)_____ **Date**_____