CRESTVIEW DENTAL

46600 Romeo Plank
Macomb, MI 48044
(586) 226-9000

Patient Name: _____
Last First Middle Date of Birth

Parent / Guardian's Name: _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to the dentist? ..... YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
4. Does your child eat between meals? ..... YES NO
5. Does your child eat sweets, such as candy, soda pop, or chewing gum? ..... YES NO
6. When does your child brush his/her teeth?
   ☐Upon arising ☐After eating any food ☐ Right after meals ☐ Before bed
7. How does your child receive fluoride?
   ☐Community water ☐Well water ☐ Fluoride drops ☐ Fluoride rinse
8. Have any cavities been noted in the past? ..... YES NO
9. Does your child suck his / her thumb or fingers? ..... YES NO
10. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
11. Have there been any injuries to the teeth, such as fall, blows, chips, etc? ..... YES NO
    If yes, describe: _____
12. Has your child ever had any problems with dental treatment in the past? ..... YES NO
13. Has anyone in the family, including parents, had orthodontics? ..... YES NO
14. Has your child ever received a local anesthetic? ..... YES NO
15. Has your child ever had occlusal sealants? ..... YES NO
16. Do you have high or low blood pressure? (if yes, please circle which) ..... YES NO
17. Does your child think there is anything wrong with his/her teeth? ..... YES NO

MEDICAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Does your child have any health problems? ..... YES NO
2. Is your child under the care of a physician? ..... YES NO
   If yes, since when and why? _____
3. Name of physician: _____
4. Is your child receiving any medications? ..... YES NO
   If yes, what? _____
5. Is your child allergic to penicillin, antibiotics, or other drugs? ..... YES NO
6. Is your child allergic to or sensitive to any metals? ..... YES NO
7. Does your child have other allergies? ..... YES NO
8. Has your child had any serious illnesses? ..... YES NO
   When? _____ What? _____
9. Has your child ever had surgery? ..... YES NO
10. Does your child have a heart murmur? ..... YES NO
11. Does your child have frequent ear infections? ..... YES NO
12. Does your child experience severe or prolonged bleeding? ..... YES NO
13. Does your child have AIDS or has he/she tested HIV positive? ..... YES NO
14. Has your child tested positive for hepatitis? ..... YES NO
15. Is your child subject to nervous disorders? ..... YES NO
    ☐Fainting? ☐Seizures? ☐ Dizziness? ☐ Behavioral / Learning problems?
16. Does your child have frequent headaches? ..... YES NO
17. Has your child had history of: (Circle appropriate responses) autism, diabetes, heart problems, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS:

I CERTIFY THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE: _____ DATE: _____

DENTIST'S SIGNATURE: _____ DATE: _____

CHILD DENTAL MEDICAL HISTORY

Med Alert