Rosenwald & Associates
Cosmetic, Restorative and Preventive Dentistry

Child Medical & Dental History Form

TODAY'S DATE _____

PATIENT NAME _____ DATE OF BIRTH _____
First Last Initial

PARENT OR GUARDIAN NAME _____
First Last Initial

CIRCLE THE APPROPRIATE ANSWER

FOR OFFICE USE ONLY

MEDICAL HISTORY

1.	Is the child in good health?	No	Yes
2.	Is the child under the care of a physician?	Yes	No
	If yes, why? _____		
3.	Physician _____ Phone # _____		
4.	Is the child taking any medication?	Yes	No
5.	Has the child had any serious illness?	Yes	No
	If so, what and when? _____		
6.	Is the child allergic to penicillin, antibiotics or any other drugs?	Yes	No
7.	Does the child have any other allergies?	Yes	No
8.	Has the child ever bled excessively from a cut or injury?	Yes	No
9.	Is the child subject to nervous disorders, fainting or dizzy spells? ..	Yes	No
10.	Has the child a history of diabetes, heart trouble, asthma, kidney infection or rheumatic fever?	Yes	No
11.	Is there anything else we should know about the child's health?.....	Yes	No
12.	*If so, what?* _____		

DENTAL HISTORY

1.	Is this the child's first visit to the dentist?	Yes	No
	*If not, how long since the last visit?*_____		
2.	When was the last time his/her teeth were cleaned?_____		
3.	Does the child eat sweets such as candy, soda pop, chewing gum? ..	Yes	No
4.	Does the child eat between meals?	Yes	No
5.	Does the child brush teeth upon rising?	No	Yes
	Before bed	No	Yes
	After eating meals?	No	Yes
	After eating snacks?	No	Yes
6.	Do you live in an area with fluoridated water?	No	Yes
7.	Have the teeth been treated with fluoride?	No	Yes
8.	Has the child had protective sealants?	No	Yes
9.	Were any teeth removed by extraction?	Yes	No
10.	Have there been any injuries to the teeth, face or jaws?	Yes	No
11.	Has the child had any unfavorable dental experiences?	Yes	No
12.	Has the child ever had local anesthetic for dental treatment?	No	Yes
13.	Do you have any preference for the type of fillings used?	Yes	No

I certify that the above information is complete and accurate.

PARENT/GUARDIAN SIGNATURE _____ Date: _____

DOCTOR SIGNATURE _____ Date: _____

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