North Seattle Smiles

Child Name _____ Date _____

Parent/Guardian _____ Relation to patient _____

Dental History

Is this your child's first visit to the dentist? ☐Yes ☐No
If No, when was their last visit _____
Previous Dentist Name _____
Any x-rays taken at the previous visit? ☐Yes ☐No
Have any cavities been noted in the past? ☐Yes ☐No
Has your child had any problems with dental treatment? If so, please explain

_____

Have they ever received local anesthetic? ☐Yes ☐No
Has your child ever had sealants placed? ☐Yes ☐No
Have there been any injuries to your child's teeth or face (falls, blows, chips, etc.)? Please explain

_____

Does your child receive fluoride by any of the following?
☐Water ☐Toothpaste ☐Drops ☐Tablets ☐Gel

How often does your child brush _____
How often does your child floss _____
Does your child have any of the following habits?
☐Nursing/Bottle at night ☐Lip sucking/biting
☐Pacifier ☐Grinding
☐Thumb/Finger sucking ☐Snoring
☐Nail Biting ☐Mouth Breathing

Are there any other considerations we should know about when treating your child? (no-fluoride, non-vaccinated, x-ray concerns, etc.?

_____
_____

Medical History

Child's Pediatrician _____
Pediatrician's Phone _____
Are they seeing any medical specialist? ☐Yes ☐No
If so, name _____
Drugs/Medications your child is taking _____
_____
Please list any allergies (drugs, latex, food, etc.) _____
_____
Has your child ever had surgery? ☐Yes ☐No
If yes, explain _____
Please discuss any serious medical conditions
_____
_____

Does your child have any of the following conditions?
☐ADD/ADHD ☐Diabetes
☐AIDS/HIV+ ☐Disabilities/Special Needs
☐Allergies ☐Easting Disorder
☐Asthma ☐Hearing/Visual Impairment
☐Autism ☐Heart Disease/Murmur
☐Blood Disorder ☐Hepatitis
☐Bone/Muscle Disorder ☐Hospital Stays
☐Cancer ☐Immune Disorder
☐Congenital Birth Defect ☐Kidney/Liver Conditions
☐Convulsions/Epilepsy ☐Rheumatic/Scarlet Fever
☐Depression/Anxiety ☐Tuberculosis
Other:
_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature of Parent _____ Date _____