14 and under

SUNSET HILLS DENTAL GROUP, INC.

Child's Name _____

CHILD'S HISTORY

DENTAL HISTORY

Date of last visit to dentist _____

For what service _____

	YES	NO
Has child complained about dental problems	☐	☐
Any unhappy dental experiences	☐	☐
Any injuries to mouth - teeth - head	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.	☐	☐
Does your child brush teeth daily	☐	☐
Do you assist child with tooth brushing	☐	☐
Is dental floss used	☐	☐
Are disclosing tablets used	☐	☐
Is fluoride taken in any form	☐	☐

Summary (for doctor's use only) _____

MEDICAL HISTORY

Child's Physician _____

Date of last physical examination _____

	YES	NO
Is child under care of physician now	☐	☐
Is child receiving any medication or drugs	☐	☐
Is there any excessive bleeding when cut	☐	☐
Has child ever been hospitalized	☐	☐
Has child ever had surgery	☐	☐
Is there any allergy to penicillin or other drugs	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐
Does child have good physical coordination	☐	☐
Are there any emotional problems	☐	☐
Ever had or has rheumatic fever	☐	☐

List any other medical problems _____

May we request release of your child's medical records for our reference ☐ ☐

This information was given by _____

Relation to Child _____

Signed _____

Form No. 5