

Dr. Angela Wandera & Associates

Pediatric Dentistry and Orthodontics

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PATIENT NUMBER

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PARENT/GUARDIAN'S NAME: _____

Please complete both sides of the form, answering all questions fully.

DENTAL HISTORY

Is your child experiencing any pain or discomfort, toothache or swelling.....YES NO

Does your child feel there is anything wrong with his/her teeth?.....YES NO

Please explain: _____

Is this your child's first visit to the dentist.....YES NO

If not, how long since the last visit to the dentist? _____

Name and city of previous dentist? _____

Were any x-rays taken? _____

What treatment was performed? _____

Has your child received any other dental or orthodontic treatment.....YES NO

Please explain: _____

Has your child received local anesthesia for dental treatment.....YES NO

Has your child had any problem with dental treatment in the past.....YES NO

Have there been any injuries to the teeth and/or jaws, such as falls, blows, chips, etc?.....YES NO

Please describe: _____

Does your child suck his /her thumb or have any other related habit?.....YES NO

Has anyone in the family, including parents, had orthodontics.....YES NO

Do you anticipate your child having difficulty accepting dental treatment.....YES NO

Are YOU anxious and fearful of this visit?.....YES NO

Do you or your child's caretaker have any untreated dental conditions.....YES NO

What is the drinking water source for your child?

City water _____ Well water _____ Bottled water _____ Filtered water _____ Other _____

Does your child receive fluoride?

Fluoride drops/tablets _____ Fluoride rinse _____ Fluoride gel _____ Toothpaste _____

Does your child snack between meals?.....YES NO

Frequency _____

Favorite Snack _____

Favorite drink/beverage _____

Who brushes your child's teeth? _____

Frequency? _____

Does your child use floss?.....YES NO

CHILD DENTAL AND MEDICAL HISTORY

OVER

Dr. Angela Wandera & Associates

Pediatric Dentistry and Orthodontics

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PATIENT NUMBER

PATIENT NAME: _____

DATE OF BIRTH: _____

PARENT/GUARDIAN'S NAME: _____

Please complete both sides of the form, answering all questions fully.

MEDICAL HISTORY

Does your child have any health problem?.....YES NO

Is your child under the care of a physician?.....YES NO
Name of physician? _____

Is your child receiving any medication.....YES NO
For what condition? _____
Medication name? _____

Is your child allergic to penicillin, antibiotics or other drugs?.....YES NO
If yes, please explain _____

Is your child allergic to metals or latex?.....YES NO

Does your child have other allergies?.....YES NO
If yes, please explain _____

Has your child had any serious illness, hospitalization or surgery?.....YES NO
When? _____ Description? _____

Does your child have a heart murmur?.....YES NO

Does your child experience severe or prolonged bleeding?.....YES NO

Does your child have AIDS or has he/she tested HIV positive?.....YES NO

Has your child tested positive for hepatitis?.....YES NO

Has your child had a history of: (Circle appropriate responses)

CONGENITAL BIRTH DEFECTS	HEART TROUBLE	ASTHMA	CEREBRAL PALSY	KIDNEY INFECTION
RHEUMATIC FEVER	LIVER PROBLEMS	DIABETES	CANCER	INFECTIONS/IMMUNE DISORDER

Is your child subject to any of the following? YES NO

Physical limitations? _____ Hearing loss? _____ Speech impediments? _____

Visual/Eyesight problems? _____ Emotional problems? _____ Learning disabilities? _____

Behavioral problems? _____ ADHD/ADD _____ Mental impairments? _____

Seizures/Epilepsy? _____ Autism? _____ Anxiety/Panic Disorder? _____

Comments? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Parent/Legal Guardian Signature _____

Date _____

Dentist's Signature _____

Date _____

CHILD DENTAL AND MEDICAL HISTORY