Dr. Angela Wandera & Associates

Pediatric Dentistry and Orthodontics

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 from any of the following sources?
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

Dr. Angela Wandera & Associates

Pediatric Dentistry and Orthodontics

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: (Check appropriate responses)

HEART TROUBLE ☐ ASTHMA ☐ CEREBRAL PALSY ☐ KIDNEY INFECTION ☐ CONGENITAL BIRTH DEFECTS ☐

CANCER ☐ DIABETES ☐ LIVER PROBLEMS ☐ RHEUMATIC FEVER ☐ 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 _____