ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: First Name: Middle Name: Nickname:

Date of Birth: / / Gender:

Parent's/Guardian's Name: Relationship to Patient:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had? ☐ A cough that's lasted longer than three weeks ☐ A cough that produces blood ☐ Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No If yes, where? _____

Is this the patient's first visit to a dentist? ☐ Yes ☐ No
If no, when was the patient's last dental exam? _____ What was done at that appointment? _____

When was the last time the patient had dental x-rays taken?

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**	**?**
Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: _____	☐	☐	☐
Has the patient had any problems with teeth coming in or losing teeth?	☐	☐	☐
Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____	☐	☐	☐
Has the patient ever worn braces or other orthodontic appliances?	☐	☐	☐
Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: _____	☐	☐	☐
Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: _____	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well			
Does the patient take fluoride supplements?	☐	☐	☐
Does/did the patient use a pacifier or suck his/her thumb or fingers? At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____	☐	☐	☐
Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep			

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