

Child's name _____ Preferred name: _____ Age: _____

Date of Birth ___/___/___ Last dental visit _____ Purpose of that visit? _____ Grade: _____

Has your child ever had any serious or difficult problems associated with previous dental treatment? Yes No
If yes, please explain: _____

Child's Physician: _____ Phone #: _____

Is your child allergic to any of the following? Penicillin Codeine Aspirin Latex Anesthetic
 My child has no known allergies

Is your child taking any prescription or non-prescription medication at the present time? YES NO

If yes, please list names and reason: _____

Does your child have or ever had any of the following medical problems? (if yes, please explain)

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Hepatitis A,B,C | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> Any hearing problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Any surgery | <input type="checkbox"/> Sickle cell disease | Other _____ |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Convulsions/Epilepsy | _____ |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Sinus Problems | |

Does your child drink fluoridated water? Yes No
 Does your child take fluoride supplements? Yes No
 Does your child brush his/her teeth daily? Yes No
 When? Morning Evening Do you help with brushing? Yes No
 Does your child regularly drinks the following? Milk Chocolate Milk Juice Soda Gatorade

Does your child have any of the following habits? Lip sucking / biting
 Nursing bottle habits
 Thumb / finger sucking

I understand that the information that I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical history. I authorize Just Smiles to perform the necessary dental services my child will need.

Parent Signature

Date