CHILD MEDICAL/DENTAL FORM

ROCK RIVER DENTAL

_____ _____ _____ _____

PATIENT NAME *(First)* *(Middle Initial)* *(Last)* *(DOB)*

_____ _(_____)_____ _____

Parent or Guardian *(Name)* *(Phone Number)* (Relationship to Patient)

_____ _(_____)_____ _____

EMERGENCY CONTACT 2 *(Name)* *(Phone Number)* (Relationship to Patient)

Medical History

1) PLEASE LIST ALL MEDICATIONS UNDER COMMENTS
   (Including vitamins, birth control, supplements or controlled substances)
2) PLEASE LIST ALL ALLERGIES UNDER COMMENTS
   (Adverse reactions to *food*, medications, anesthetics, antibiotics, latex, etc)
3) Is the child currently being treated for anything by a physician? **YES NO**
   Describe: _____
4) Has the child ever had any serious illness? _____ **YES NO**
5) Has the child ever had a blood transfusion? **YES NO**
6) Has the child ever been hospitalized? (for what: _____ **YES NO**
7) Does the child have any speech or hearing difficulties? _____ **YES NO**
8) Is the child physically, mentally, or emotionally impaired? (circle) **YES NO**
9) Does the child experience excessive bleeding? **YES NO**
10) Does the child actively participate in recreational activities? **YES NO**

Dental History

1) Does the child have any habits? (sucking thumb, biting nails, etc) **YES NO**
   Describe: _____
2) Does the child currently take any fluoride supplements?_____ **YES NO**
3) Does the child currently use fluoridated toothpaste? **YES NO**
4) At what ***age*** did the child stop bottle feeding? _____ **N/A**
5) At what ***age*** did the child stop breastfeeding? _____ **N/A**
6) Frequency of brushing (***per day***)? _____
7) When are teeth brushed during the day? _____
8) Frequency of flossing (**per day**)? _____
9) What type of water does your child drink? (please circle)
   City Water Well Water Bottled Water Filtered Water
10) Is this the child's ***first*** visit to a dentist? (if no, last visit:_____)**YES NO**
11) Has the child had any problems with previous dental treatment? **YES NO**
    Describe: _____
12) Has the child ever had dental radiographs (x-rays) taken? **YES NO**
13) Has the child ever suffered injury to mouth, head and/or teeth? **YES NO**
14) Has the child had problems with eruption or shedding of teeth? **YES NO**
15) Has the child ever had any orthodontic treatment? **YES NO**

COMMENTS

Medications

-
-
-
-
-
-
-
-
-
-

Allergies

-
-

BP: Date:

_____ _____
_____ _____
_____ _____
_____ _____

Patient Review: Date:

_____
_____
_____

Doctor Review: Date:

_____
_____
_____

I certify the above information is complete and accurate.

Patient/Guardian Signature _____ *DATE* _____

Doctor Signature _____ *DATE* _____