



Smiles 4 Kids

Children's General Dentistry



Child's Legal Name: _____ Today's Date: _____

Date of Birth: _____ How did you hear about us? _____

Male Female

*DOES YOUR CHILD HAVE A CURRENT USE OF ANY OF THE FOLLOWING?

Nursing/bottle habits Thumb/Finger Sucking

Pacifier Dental Grinding

* **Health History** (For children only)

Patient's Primary Care Physician: _____ Phone: _____

Is patient currently taking any medications? NO YES If yes, what? _____

Is patient allergic to any of the following?

Aspirin Penicillin/Amoxicillin Latex Foods Metals/Acrylics Other: _____

AIDS/HIV	Y / N	DRUG/ALCOHOL USE	Y / N	ALLERGIES	Y / N
ANEMIA	Y / N	FAINTING/DIZZINESS	Y / N	ARTIFICIAL JOINTS/PINS	Y / N
ASTHMA/BREATHING PROBLEMS	Y / N	HEPATITIS	Y / N	LIVER DISEASE	Y / N
AUTISM	Y / N	HEART MURMUR	Y / N	HEART SURGERY	Y / N
ARTHRITIS	Y / N	KIDNEY DISEASE	Y / N	PREGNANCY	Y / N
HYPERACTIVITY, ADHD/ADD	Y / N	LEUKEMIA	Y / N	HEADACHES	Y / N
EXCESSIVE GAGGING	Y / N	FEVER BLISTERS	Y / N	GROWTH PROBLEMS	Y / N
BIRTH DEFECTS	Y / N	SICKLE CELL ANEMIA	Y / N	DIABETES	Y / N
EXCESSIVE BLEEDING/CLOTTING PROBLEMS	Y / N	TUBERCULOSIS	Y / N	SPEECH/HEARING PROBLEMS	Y / N
BLOOD DISEASE/TRANSFUSIONS	Y / N	DISABILITIES/SPECIAL NEEDS	Y / N	CONVULSIONS/SEIZURES	Y / N
BRAIN INJURY	Y / N	BRUISE EASILY	Y / N	DEVELOPMENTALLY DELAYED	Y / N
CHILD ABUSE	Y / N	CANCER/CHEMOTHERAPY	Y / N	EMOTIONAL DISTURBANCE	Y / N
CHRONIC ADENOID/TONSIL PROBLEMS	Y / N	CEREBRAL PALSY	Y / N	PSYCHIATRIC CARE	Y / N
HOSPITALIZATION IN THE PAST 5 YEARS	Y / N	PRIOR ANESTHETIC COMPLICATION	Y / N	Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, or other medical reason?	Y / N
MOTHER WITH HISTORY OF DENTAL DECAY	Y / N				

If you answered "yes" to any of the above, please explain _____

*Legal Guardian Name (PLEASE PRINT): _____ Date _____

*What relationship are you to the patient: _____