MOFFITT CHILDREN'S DENTISTRY

Patients Name_____ Nickname_____ Male_____ Female_____

Birth date_____ Age_____

DENTAL HISTORY

Reason for today's visit:_____

Is this the Patient's first visit to the dentist? Yes / No
If no, date of last visit?_____ Date of last X-rays:_____
Was this a good experience? Yes / No
Name of former Dentist:_____ Phone:_____ General / Pediatric

Would you describe you child as? Shy Frightened Apprehensive Relaxed

Yes No Does your child brush daily?
Yes No Does an adult assist with brushing?
Yes No Does your child floss?
Yes No Does an adult assist with the flossing?
Yes No Does your child receive fluoride in any of the following form?
__In Vitamins __In Water Supply __In Toothpaste __In Tablets/Drops

Check if your child has had any of the following mouth habits or conditions?

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Lips
- ☐ Dry Mouth
- ☐ Fingernail Biting
- ☐ Finger Sucking
- ☐ Grinding Teeth
- ☐ Gums Swollen or Tender Mouth
- ☐ Jaw pain or tenderness
- ☐ Loose teeth or broken fillings
- ☐ Lip/Thumb Sucking
- ☐ Orthodontic treatment
- ☐ Mouth Breathing
- ☐ Pacifier
- ☐ Sensitivity to (please circle) Cold / Hot / Sweets

MEDICAL HISTORY

Child's Physician:_____ Phone:_____ Date of Last Physical:_____

Yes No Is your child in good health?
Yes No Has your child ever been hospitalized? Explain (date) _____
Yes No Is your child currently being treated for any conditions? Explain _____

Has your child ever been diagnosed as having any of the following conditions? (Use backside of this sheet if further explanation is needed)

- ☐ Asthma
- ☐ Autism
- ☐ ADHD
- ☐ Bladder Conditions
- ☐ Brain Injury
- ☐ Bruising Easily
- ☐ Cancer or Malignancies
- ☐ Cerebral/Neurological Condition
- ☐ Convulsions / Seizures
- ☐ Diabetes
- ☐ Developmental Delay
- ☐ Ear Infections
- ☐ Excessive Gagging
- ☐ Excessive Bleeding
- ☐ Emotional/Mental Disturbance
- ☐ Epilepsy
- ☐ Fainting / Dizziness
- ☐ Heart Problems
- ☐ Hearing/Speech Problems
- ☐ Hepatitis/Kidney Disease
- ☐ HIV/AIDS Virus
- ☐ Rheumatic Fever
- ☐ Tonsil Problems
- ☐ Tuberculosis

MEDICATIONS

List medications your child is currently taking:

_____

_____

ALLERGIES

☐ Aspirin ☐ Penicillin ☐ Sulfa
☐ Local Anesthetic ☐ Latex
Other_____

AUTHORIZATION

To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to my child's health. If my child ever has a change in his/her health or medicines, I will inform the doctor. I hereby authorize treatment by the doctor and the dental staff in caring for my child.

Signed:_____ Date:_____