

# Infant/Toddler Dental History

Patient's Name \_\_\_\_\_

Has your child been seen by a dentist before?  No  Yes

If yes: Former Dentist \_\_\_\_\_ Location (City): \_\_\_\_\_

How often do you brush your child's teeth? \_\_\_\_\_

How often do you floss your child's teeth? \_\_\_\_\_

When did the first tooth come in? \_\_\_\_\_

Any unusual teething difficulties? \_\_\_\_\_

Any history of trauma to the mouth? \_\_\_\_\_

Describe any oral habits (pacifier use, thumb-sucking, etc): \_\_\_\_\_

Was your child primarily:  Bottle fed  Breast fed

Does your child go to bed with a bottle?  No  Yes

Do you use the bottle as a pacifier?  No  Yes

Do you use:  City water  Community well  Well-water  Bottled water  Filtered water

Other information or concerns about your child's dental health or previous treatment \_\_\_\_\_

## Medical History

Pediatrician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Has your child had any serious illnesses or operations?  No  Yes

If yes, describe \_\_\_\_\_

Check if your child has had any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> AIDS/HIV                             | <input type="checkbox"/> Heart problems   |
| <input type="checkbox"/> ADD/ADHD                             | <input type="checkbox"/> Hemophilia/abnormal bleeding                                   |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Hepatitis  |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Kidney disease/malfunction                                     |
| <input type="checkbox"/> Autistic                             | <input type="checkbox"/> Liver disease/problems   |
| <input type="checkbox"/> Blood disease                        | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Rheumatic/Scarlet fever  |
| <input type="checkbox"/> Food allergies                       | <input type="checkbox"/> Significant fever (over 103 degrees for more than a few hours) |
| <input type="checkbox"/> Frequent or long uses of antibiotics | <input type="checkbox"/> Tetracycline use   |
| <input type="checkbox"/> Heart murmur (Mitral valve prolapse) | <input type="checkbox"/> Was Pre-term or low-birth weight infant                        |

List any medications your child is currently taking: \_\_\_\_\_

List any drug allergies: \_\_\_\_\_

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in medical status, I will inform the dentist. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child: \_\_\_\_\_