

CRAIG R. CAMERON, DDS, PLC
CHILD'S DENTAL HEALTH HISTORY
(Confidential)

Child's Name: _____ Today's Date _____
Birthdate _____
Last First Initial Age _____

Just a reminder - talk positively about dental treatment to your child to help make their visit more pleasant.

DENTAL HISTORY

Reason for today's visit _____
Former Dentist (if applicable) _____ Address _____
Date of last dental care _____ Date of last dental x-rays _____

	YES	NO
Has your child complained about dental problems?	_____	_____
Do you assist your child with toothbrushing and flossing?	_____	_____
Is your child's water fluoridated?	_____	_____
Does your child take fluoride supplements?	_____	_____
Any injuries to mouth, teeth, or head?	_____	_____
Any unhappy dental experiences?	_____	_____
Any mouth habits - thumbsucking, nail biting, mouth breathing, Pacifier, sleeping with a bottle, etc?	_____	_____
Any unusual speech habits?	_____	_____
Does your child drink sweetened pop/soda/juice/vitamin water?	_____	_____
How often does your child brush his/her teeth? _____		
How often does your child floss his/her teeth? _____		

MEDICAL HISTORY

Minor Child's Physician's Name _____
Address _____ Phone # _____

Date of last physical exam? _____ Child's Weight _____

Does your child have or has your child ever had:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Abnormal Heart Condition/Surgery	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Abnormal Bleeding from Cut	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Insulin Pump	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Epilepsy/Convulsions/Seizures
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Other Physical Condition
<input type="checkbox"/> Cancer		

Has your child's physician requested your child premedicate before dental procedures? _____

MEDICATIONS

Is any medication being taken now? _____ If so, what medication, along with dosage, frequency, and for what condition?

Pharmacy Name: _____ Phone _____ - _____

ALLERGIES

Do you have any of the following allergies?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Ibuprofen (NSAID)	<input type="checkbox"/> Foods
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Local Anesthetic (Novocaine)	<input type="checkbox"/> Jewelry/Metals (eg. Nickel, copper)	
<input type="checkbox"/> Other, please indicate _____				

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I will not hold the dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature of Parent or Guardian _____

MEDICAL HISTORY UPDATE

Has there been any changes in your health since your last dental appointment? ___Yes___No
For What Conditions? _____

Is the child taking any new medications? _If so, what _____

Does your child have any new allergies? _____ If so, to what _____

Date _____ Signature _____

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