Parent or Guardian's name:_____

Is this your child's first visit to a dentist? **YES/NO** Emergency visit**? YES/NO** Regular check-up? **YES/NO**

In your opinion, what is the dental problem?_____

_____

Has your child had any history of: (please circle)

Abscessed tooth	YES NO	Anemia	YES NO
Broken tooth	YES NO	Asthma	YES NO
Cavities	YES NO	Brain damage	YES NO
Crooked tooth	YES NO	Convulsions	YES NO
Extracted tooth	YES NO	Diabetes	YES NO
Grinding of teeth	YES NO	Ear Infection	YES NO
Gum infection	YES NO	Excessive bleeding	YES NO
Toothache	YES NO	Hearing problem	YES NO
Thumb/finger/pacifier habit	YES NO	Heart problem	YES NO
Hepatitis	YES NO	Kidney disease	YES NO
Learning disability	YES NO	Liver disease	YES NO
Mental retardation	YES NO	Mouth breathing	YES NO
Radiation therapy	YES NO	Rheumatic fever	YES NO
Seizures	YES NO	Speech disturbance	YES NO
Tuberculosis	YES NO	Tumors	YES NO
Tonsil/adenoid problems	YES NO	Acquired Immune Deficiency Syndrome	YES NO

If you answered **YES** to any of the above, please explain:_____

_____

Who is your child's physician?_____Last visit?_____

Is Your child taking any medications? (*please list*)_____

Is your child ALLERGIC to anything? (*please list*)_____