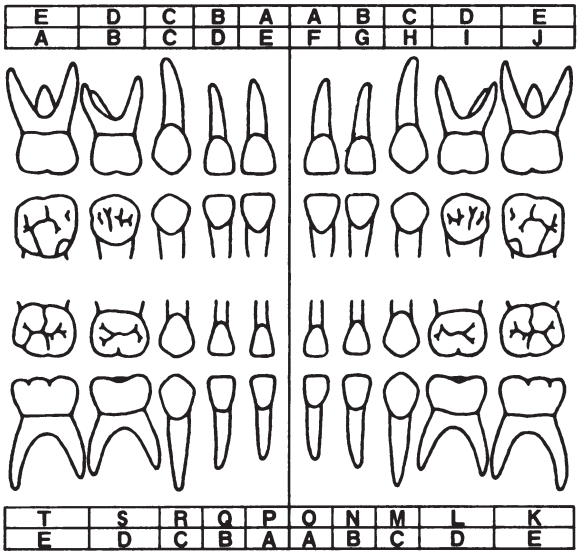
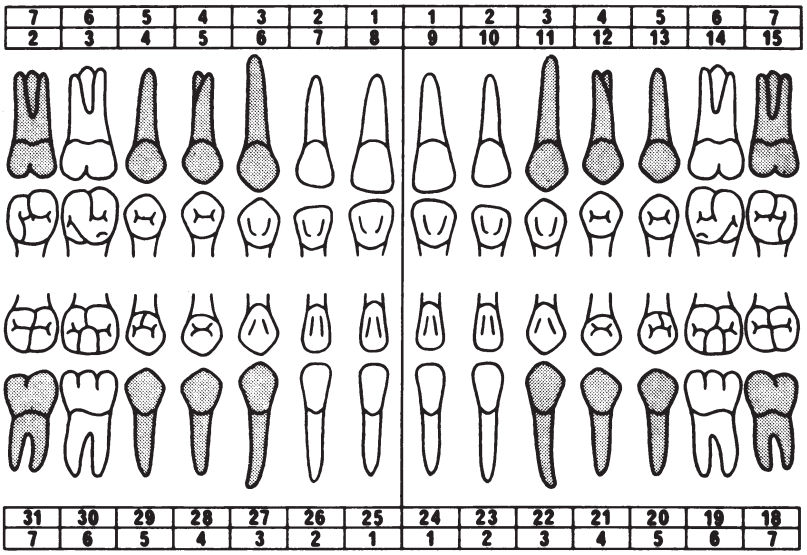
MEDICAL ALERT →

NAME _____ DATE _____ AGE _____





MEDICAL HISTORY SUMMARY

1. Existing illnesses _____
_____
2. Current medications_____
_____
3. Allergies _____
_____
4. Nutritional eval. _____

DENTAL HISTORY SUMMARY

1. Chief concern _____
_____
2. Oral habits _____
_____
3. Oral hygiene _____
4. Caries risk _____
5. Preventive Recare 3 4 6 months

DENTAL *ORO-FACIAL* EXAM

(Circle Abnormalities and Explain)

I. Dentition

Hypoplasia	Ankylosis	Supernumerary
Hypocalcification	Eruption Sequence	Over-retention
Fluorosis	Eruption Status	Congenitally Missing
Discoloration/Staining	Normal/Adv/Delayed	Size and shape

Other _____

II. Occlusion and Functional Relations

ANGLE'S BITE CLASSIFICATION 6's/E's 3's/C's

Overbite _____%	Open Bite _____mm	Crowding/Spacing	Facial profile_____
Overjet _____mm	Midline deviation	Rotations	Arch length deficiency
Crossbite _____	Other _____		

III. Gingiva and Periodontium

Plaque: light/moderate /heavy	Calculus	Bleeding: localized/ generalized	Probing depths _____ PSR _____

IV. Soft and Hard Tissue

Face	Oro-pharynx	Salivary glands	Lymph nodes
Lips	Palate	Tongue	T.M.J.
Floor of mouth	Cheeks	Frenum	Other _____

Other Notes:

_____

_____

Child's Name: _____
Date of birth: _____
Date: _____

Medical and Dental History

Your child's overall health, as well as any medications that he/she takes, may have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Medical History

Child's Physician: _____
Physician's Address:_____
_____
Date of last physical: _____

Has your child ever had any of the following?

Asthma	☐yes	☐no
Cancer/Tumors	☐yes	☐no
Hepatitis	☐yes	☐no
HIV/AIDS	☐yes	☐no
Hemophilia	☐yes	☐no
Diabetes	☐yes	☐no
Kidney problems	☐yes	☐no
Liver/GI problems	☐yes	☐no
Endocrine abnormalities	☐yes	☐no
Allergies(seasonal)	☐yes	☐no
Allergies(food,drug)	☐yes	☐no
Explain _____		
Hearing problems	☐yes	☐no
Eye disorders	☐yes	☐no
Breathing/lung problems	☐yes	☐no
Blood disorders	☐yes	☐no
Adverse drug reaction	☐yes	☐no
Rheumatic fever	☐yes	☐no
Congenital heart defect	☐yes	☐no
Congenital birth defect	☐yes	☐no
Mental/Physical developmental delays	☐yes	☐no
Behavioral/learning problems	☐yes	☐no
Seizures/Epilepsy	☐yes	☐no
Social development delays	☐yes	☐no
Recurrent /frequent headaches	☐yes	☐no
Tuberculosis	☐yes	☐no
Frequent infections	☐yes	☐no
Significant injuries	☐yes	☐no
Explain _____		
Hospitalizations	☐yes	☐no
When _____		
Abnormal bleeding	☐yes	☐no
History of blood transfusion	☐yes	☐no
Date _____		
Heart ailments	☐yes	☐no
Heart murmur	☐yes	☐no
Type _____		
Premed Needed	☐yes	☐no

Please explain any other medical problems that your child has_____
_____
_____
_____
_____

Child's Medications

Please list your child's medications and dosages.
_____
_____
_____

Dental History

What are your main concerns about your child's dental health?_____
_____
How frequently are your child's teeth brushed?____
How frequently are your child's teeth flossed? ____
Do you help your child with brushing and flossing? ☐yes ☐no
Date of last dental visit_____Xrays_____
Previous dentist _____
How would you describe your last dental experience?
_____
Does your child have a healthy diet?_____
Does your child's family have a history of dental decay or gum disease? ☐yes ☐no
Is your child's drinking water fluoridated? ☐yes ☐no
Does your child take a fluoride supplement?
Dosage _____ ☐yes ☐no
Does your child:
Suck thumb/finger/lips/pacifier ☐yes ☐no
Bite/chew nails or hard objects (pencils, etc) ☐yes ☐no
Grind teeth/clench jaws ☐yes ☐no
Use a bottle/sippy cup ☐yes ☐no
Breast feed/how long?_____ ☐yes ☐no
Eat/drink after brushing ☐yes ☐no
Brush before bed ☐yes ☐no
Drink more than 1 glass of juice, tea, soda or sports drink per day ☐yes ☐no
Have a history of dental trauma? ☐yes ☐no

Authorization and Release

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 authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such dental care to third party payers and/or health practitioners. I also consent to any necessary radiographs (x-rays) needed for proper diagnosis.

X_____
Signature of parent/guardian date