WELCOME
J. Brant Darby D.D.S, PC
Pediatric Dental Specialist

ABOUT YOUR CHILD

_____
Child's Name

_____ ☐M or ☐F _____
Age Date of Birth

READING FOR THIS VISIT
_____
_____
_____

REFERRED TO THIS OFFICE BY (We wish to thank them):

_____
Full Name Phone number

DENTAL HISTORY

Is this your child's first dental visit? ☐ Yes☐ No

_____
Previous Dentist City

_____
Date of last visit

Were dental x-rays taken? ☐ yes ☐no
If yes when?_____

Any injuries to your child's teeth or jaws?_____
When? _____

History of: When?
☐ Breast feeding _____
☐ Bottle habits _____
☐ Thumb/finger sucking _____
☐ Pacifier _____
☐ Dental grinding/clenching_____

Has your child experienced any unfavorable reaction from previous medical or dental care?
☐ yes ☐ no (If yes, please explain)

_____
_____

Has your child had recent dental pain?

_____

MEDICAL HISTORY

* Is your child presently under the care of your family physician for any medical reason? ☐ Yes ☐No
If yes, what? _____

_____
Date of last physical exam

_____
Family physician's name Phone number

*Is your child presently under the care of a specialist for any medical reason? If yes, explain._____
*Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt, or other medical reason?
*Is your child presently taking medications?
If so, what? _____
*Has your child ever been hospitalized or had surgery?
For what? _____
*Does your child have any allergies to medications, food, latex, other? If so what? _____
*Has any member of the family, including your child, had a problem with general anesthesia? ☐ Yes ☐No

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

Y	N		Y	N	
☐	☐	Aids-HIV	☐	☐	Excessive gagging
☐	☐	Anemia	☐	☐	Fainting or dizziness
☐	☐	Arthritis	☐	☐	Fever blisters
☐	☐	Asthma	☐	☐	Growth/developmental problem
☐	☐	Autism	☐	☐	Heart surgery
☐	☐	Bladder conditions	☐	☐	Headaches
☐	☐	Blood disease	☐	☐	Hearing/Speech Impairments
☐	☐	Blood transfusions	☐	☐	Heart Murmur/Defect
☐	☐	Birth defects	☐	☐	Hemophilia
☐	☐	Bone or joint problems	☐	☐	Hepatitis/Liver Disease
☐	☐	Brain injury	☐	☐	High Blood Pressure
☐	☐	Bruising easily	☐	☐	Kidney Disease
☐	☐	Cancer	☐	☐	Leukemia
☐	☐	Cerebral palsy	☐	☐	Mental Disability
☐	☐	Chemotherapy/radiation	☐	☐	Mouth Sores
☐	☐	Child abuse	☐	☐	Nutritional Deficiency
☐	☐	Chronic ear infections	☐	☐	Orthopedic Problems
☐	☐	Cleft lip/palate	☐	☐	Pain in Jaw Joints
☐	☐	Congenital heart lesion	☐	☐	Premature Birth
☐	☐	Convulsions/seizures	☐	☐	Psychiatric Care
☐	☐	Diabetes	☐	☐	Rheumatic Fever
☐	☐	Drug addiction	☐	☐	Scoliosis
☐	☐	Emotional disturbance	☐	☐	Sickle Cell Anemia
☐	☐	Epilepsy	☐	☐	Syndrome_____
☐	☐	Eye problems	☐	☐	Tonsil infection
			☐	☐	Tuberculosis
			☐	☐	Other_____