David J. Wright, DDS
www.doctordavewright.com

Patient's Name _____ Date of Birth _____

To provide you with the best treatment and safest possible care, please take a moment to fill out this health form.

Physician _____
Address _____
Tel _____

Please check "Yes" or "No" to indicate if your child has any of the following:

Yes No
- ☐ ☐ Is this your child's first dental visit?
- ☐ ☐ Have there been any injuries to teeth, such as falls, blows, etc?
- ☐ ☐ Problems with previous dental visits
- ☐ ☐ Has your child ever been "numb" before at a dental office?
- ☐ ☐ Has your child had dental sealants yet?
- ☐ ☐ Does your child suck their finger/ thumb?
- ☐ ☐ Sensitivity to hot/cold/ sweets/chewing
- ☐ ☐ Is your child unhappy with their smile?
- ☐ ☐ Mouth breather
- ☐ ☐ Cold sores/ oral ulcers
- ☐ ☐ Blisters in the mouth
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Heart problems (i.e. mitral valve prolapse, murmur)
- ☐ ☐ Does your child have a heart murmur?
- ☐ ☐ PreMed needed before dental appointments (antibiotics,etc.)
- ☐ ☐ Serious illness/major surgery
- ☐ ☐ Radiation/chemo treatment
- ☐ ☐ Cancer

Yes No
- ☐ ☐ Blood disorders (anemia, leukemia, etc.)
- ☐ ☐ Bleeding abnormally long
- ☐ ☐ HIV / AIDS
- ☐ ☐ Hepatitis Type ___
- ☐ ☐ Stomach problems
- ☐ ☐ Kidney problems
- ☐ ☐ Liver problems
- ☐ ☐ Back problems
- ☐ ☐ Diabetes
- ☐ ☐ Nervous disorder (cerebral palsy, etc.)
- ☐ ☐ Mental disorder
- ☐ ☐ Seizures
- ☐ ☐ Fainting/dizzy spells
- ☐ ☐ Epilepsy
- ☐ ☐ Behavioral/Learning difficulties
- ☐ ☐ ADD/ ADHD
- ☐ ☐ Respiratory problems
- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis (TB)
- ☐ ☐ Frequent Headaches or migraines

Yes No
- ☐ ☐ Sinus trouble/ pain
- ☐ ☐ Pain or difficulty when chewing
- ☐ ☐ Ear stuffiness
- ☐ ☐ Ringing in the ears
- ☐ ☐ Pain or pressure behind eyes

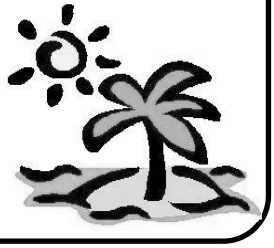
- ☐ ☐ Under physician's care
- ☐ ☐ Taking any medications/ supplements (please list below)
- ☐ ☐ **Allergies to medications** (penicillin, codeine, amoxicillin, aspirin, erythromycin, latex,etc.)
- ☐ ☐ Sensitivity to latex or metals
- ☐ ☐ **Have you been told to give your child antibiotics before dental visits**?
- ☐ ☐ **Is there anything else we should know about your child's health that we have not covered in this form?**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. *I also certify that I have received the Dental Materials Fact Sheet and the Privacy Notice.*

_____
PATIENT/GUARDIAN DATE

_____
DENTIST SIGNATURE DATE

Please list all medications your child is currently taking:



CHILD HEALTH HISTORY