DEVON PEDIATRIC DENTISTRY
Robert Raymond, D.M.D.

Patient's Name: ____ I like to be called: _________________
Parent/Guardian's Name: _______________________________________ Date of Birth: _________________

DENTAL HISTORY

Is this your child's first visit to the dentist? **YES NO**
If not, when was his/her last dental appt. ________________
Has your child had *any* problems in the past with dental treatment? **YES NO**
Please describe: ____
Were any x-rays taken at any previous dental appointments? **YES NO**
Does your child frequently eat between meals? **YES NO**
Does your child frequently eat or drink sweets such as gatorade, soda, candy, fruit snacks or chewing gum? **YES NO**
Does your child breastfeed throughout the night or take a bottle to bed? **YES NO**
Have any cavities been noted in the past? **YES NO**
Were any teeth (baby or permanent) removed by extraction? **YES NO**
Was a space maintainer used? **YES NO**
Has your child been seen by an orthodontist? **YES NO**
Has anyone in the family, including parents, had orthodontics? **YES NO**
Does your child have a thumb, finger or pacifier habit? **YES NO**
Have there been any injuries to the teeth such as falls, blows to the mouth, chips, etc.? **YES NO**
Please describe: ____
Has your child ever received a local anesthetic? **YES NO**
Has your child ever had occlusal sealants? **YES NO**
Does your child think there is anything wrong with his/her teeth? **YES NO**
Please describe: ____
How old was your child when his/her first tooth erupted? ______ months
When does your child brush his/her teeth?
___Upon rising ___After eating any food ___ Right after meals ___Before bed
Does your child take a prescription fluoride supplement? **YES NO**
(This can be in drop or tablet form and may be in combination with a multi-vitamin with a multi-vitamin prescription from your pediatrician)

Please circle any additional fluoride that your child is using:
Regular fluoride toothpaste, Bottled water with fluoride
Prescription fluoride toothpaste, Fluoride rinse or gel

MEDICAL HISTORY

Does your child currently have any health problems? **YES NO**
Please explain:____
Name of physician:____
Is your child receiving any medications? **YES NO**
Please list:____
Is your child allergic to penicillin, antibiotics or other drugs? **YES NO**
Does your child have other allergies? **YES NO**
Please list:____
Has your child had any serious illnesses? **YES NO**
Please explain:____
Has your child ever had surgery? **YES NO**
Please explain:____
Does your child have a Heart Murmur? **YES NO**
Has your physician informed you that your child needs to take antibiotics before dental treatment? **YES NO**
Does your child experience severe or prolonged bleeding? **YES NO**
Does your child have AIDS or has he/she tested HIV positive? **YES NO**
Has your child tested positive for Hepatitis? **YES NO**
Does your child have frequent headaches? **YES NO**
Is your child subject to nervous disorders? **YES NO**
Has your child had a history of any of the following conditions?

Please circle the appropriate responses:
Asthma, Behavioral/Learning Problems, Cancer, Cerebral Palsy, Congenital Birth Defects, Diabetes, Dizziness, Eyesight Problems, Epilepsy, Fainting, Hearing Loss, Heart Trouble, Infections, Kidney Infections, Liver Problems, Mental Retardation, Rheumatic Fever, Seizures, Speech Impairments.

I certify that the above dental and medical information is complete and accurate.

Parent/Guardian Signature: ______________________________________
Date: ________________