

Chesheim Dental Associates

(Children Ages Birth to 6 Years)

Please complete the following form so that we may be able to treat your child in the best manner possible.
All information is strictly confidential.

TODAY'S DATE _____
YOUR CHILD'S NAME (first/middle initial/last) _____
AGE _____ BIRTHDATE _____ BIRTHPLACE _____
SEX _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____
TELEPHONE _____
SCHOOL PRESENTLY ATTENDING _____ GRADE _____

PHYSICIAN'S NAME _____
ADDRESS _____
TELEPHONE _____

FATHER'S NAME _____
ADDRESS _____
OCCUPATION _____ EMPLOYER _____
BUSINESS TELEPHONE _____

MOTHER'S NAME _____
ADDRESS _____
OCCUPATION _____ EMPLOYER _____
BUSINESS TELEPHONE _____

BROTHERS (names/ages) _____
SISTERS (names/ages) _____
PETS _____
FAVORITE ACTIVITIES/HOBBIES _____

DENTAL HISTORY (please circle the appropriate answer as it applies)

Is this your child's first visit to the dentist? YES / NO
If not, which dentist(s) treated your child? _____
How long has it been since your child's last visit to the dentist? _____
Were any dental x-rays or radiographs taken? YES / NO
Was your child bottle or breast-fed? _____ Did he/she take a bottle to bed/naptime? YES / NO
At what age was he/she weaned to solid food? _____
Does your child or did your child suck his/her fingers/thumb or use a pacifier? YES / NO
Does your child use a sippy cup other than at mealtime? YES / NO
Does your child eat between meals? YES / NO
Does your child eat sweets, such as candy, soda, or gum? YES / NO
Will your child eat fresh fruits and vegetables? YES / NO
When does your child brush his/her teeth? Morning After eating any food After each meal Before bedtime
How does your child receive fluoride? Community water Drops, tablets, or vitamin Toothpaste Rinse or gel
Have any cavities been noted in the past? YES / NO
Were any teeth (baby or permanent) removed by extraction? YES / NO
Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES / NO
If so, please specify _____
Has your child ever had any problem with dental treatment? YES / NO
Has anyone in the family, including parents, had orthodontics? YES / NO
Has your child ever received a local anesthetic? YES / NO
Have you ever had or heard of nitrous oxide analgesia? YES / NO
Has your child ever had preventive sealants? YES / NO

Does your child think there is anything wrong with his/her teeth? YES / NO
If so, please specify _____

MEDICAL HISTORY (please circle the appropriate answer)

Does your child currently have a health condition? YES / NO
If so, what condition does he/she have, and for how long? _____

Which physician or specialist does he/she see? _____
Does your child take any medications? YES / NO

If so, which medications? _____
Is your child allergic to penicillin, antibiotics, or other drugs? YES / NO
Does your child have any allergies? YES / NO
Has your child ever been hospitalized? YES / NO
If so, when and for what reason? _____

Does your child have severe or prolonged bleeding? YES / NO
Does your child have a heart murmur? YES / NO
Has your child ever tested positive for hepatitis? YES / NO
Does your child have AIDS or has he/she tested HIV positive? YES / NO
Is your child subject to nervous conditions? YES / NO
Is your child subject to any of the following: Fainting Seizures Dizziness Behavioral/learning issues

Has your child had a history of: (please circle appropriate responses)

Asthma	Rheumatic fever	Congenital birth defects	Hearing loss
Heart trouble	Pneumonia	Speech impairments	Infection
Diabetes	Liver problems	Mental retardation	High fevers
Cerebral palsy	Frequent colds	Ear/nose/throat problems	Cancer
Growth problems	Kidney infection	Eyesight problems	Epilepsy
Serious accidents	Serious operations	Nutritional disorder	Difficult birth

Please comment on any of the above questions that were answered yes or circled.

SIGNATURE OF PARENT OR GUARDIAN _____ Date _____

Relation to child _____

How were you referred to this dental practice? _____

*Thank you for completing this form.
Please do not hesitate to ask the doctor any questions about your child's dental health at any time.*

**Parents or guardians are requested to remain in the office while their children are receiving treatment.
Thank You.**