

# Chesheim Dental Associates

(Children Ages 7 to 13 Years)

Please complete the following two-sided 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  
Does your child or did your child suck his/her fingers/thumb or bite his/her nails? 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.**