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_____

Child's Name _____ Preferred Name_____

Age _____ Birthdate _____ Sex_____ Birthplace_____

Social Security Number_____ Telephone_____ Family Email_____

Address_____

School Presently Attending_____ Grade_____

Parent/Guardian #1 Name _____ Relation to Child _____

Address_____ Cell Phone_____

Occupation _____ Employer _____ Business Phone_____

Parent/Guardian #2 Name _____ Relation to Child _____

Address_____ Cell Phone_____

Occupation _____ Employer _____ Business Phone_____

Siblings (names/ages) _____

Pets_____ Favorite Activities/Hobbies_____

Pediatrician Name _____ Office Phone _____

Address _____

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

What are your child's favorite snacks? _____

Does your child eat sweets, such as candy, or gum? YES / NO

Will your child eat fresh fruits and vegetables? YES / NO

What are your child's favorite drinks? _____

When does your child brush his/her teeth?____ Morning _____ After snacks _____ After meals _____ Before bedtime

Does your child receive fluoride? _____ Community water _____ Drops, tablets, or vitamin _____ Toothpaste ____ Rinse

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 as it applies.)*

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 medications? YES / NO

Does your child have any allergies? YES / NO

If so, which allergies? _____

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

History of any of the following: _____ Fainting _____ Seizures _____ Dizziness _____ Behavioral/learning issues

Has your child had any history of: *(Please circle appropriate responses.)*

Asthma	Rheumatic fever	Congenital birth defects	Hearing loss
Heart trouble	Pneumonia	Speech impairments	Infection
Diabetes	Liver problems	Intellectual disability	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
Acid Reflux	Sensory problems	ADHD	Social problems

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

SIGNATURE OF PARENT OR GUARDIAN _____ Date_____

Relation to child _____ Who may we thank for referring you? _____

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.