



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
 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: _____

Dentist's Signature: _____ Date: _____

