

Dental History

FLOSS

Is the child currently in pain? Yes No What is the primary reason for today's visit? _____

Has the child experienced problems with previous dental work? Yes No

Does the child brush his / her teeth daily? Yes No

Floss his / her teeth daily? Yes No

Previous / Present Dentist: _____ Date of last visit: _____
(Please Circle)

Does / did the child have any of the following habits?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Lip Sucking/Biting | <input type="checkbox"/> Clenching/Grinding Teeth | <input type="checkbox"/> Tongue/Cheek Biting | <input type="checkbox"/> Mouth Breather |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Thumb/Finger Sucking | <input type="checkbox"/> Used Pacifier | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Chewing on Objects | <input type="checkbox"/> Nursing Bottle Habits | <input type="checkbox"/> Tongue Thrust | <input type="checkbox"/> Breast Fed |

Medical History

Child's Physician: _____ Phone #: _____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? Yes No Please explain: _____

Please describe the child's current physical health: Good Fair Poor Are Immunizations Current? Yes No

Please list all drugs that the child is currently taking: _____

Besides the following, please list all drugs and/or things that cause the child allergic reactions:

Latex? Yes No Metals/Nickel Yes No Plastic? Yes No Penicillin? Yes No Tetracycline? Yes No

Anything you would like to discuss with the Doctor in private? Yes No

Has the child had/experienced any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Murmur - Innocent | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Heart Murmur - Premed | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Any Hospital Stay / Operations | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Hives | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Cerebral Palsy | | <input type="checkbox"/> Measles | |

Please discuss any serious medical problems the child experiences/ed: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Kubovich and the dental team to examine, clean and provide dental treatment on my child's teeth. I further authorize the taking of dental x-rays as may be considered necessary by Dr. Kubovich to diagnose and/or treat my child's dental problem. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature _____

Date _____

