

David J. Wright, DDS

www.doctordavewright.com

Patient's Name _____ Date of Birth _____

To provide you with the best treatment and safest possible care, please take a moment to fill out this health form.

Physician _____

Address _____

Tel _____

Please check "Yes" or "No" to indicate if your child has any of the following:

- Yes No**
- Is this your child's first dental visit?
 - Have there been any injuries to teeth, such as falls, blows, etc?
 - Problems with previous dental visits
 - Has your child ever been "numb" before at a dental office?
 - Has your child had dental sealants yet?
 - Does your child suck their finger/ thumb?
 - Sensitivity to hot/cold/ sweets/chewing
 - Is your child unhappy with their smile?
 - Mouth breather
 - Cold sores/ oral ulcers
 - Blisters in the mouth
 - Rheumatic Fever
 - Heart problems (i.e. mitral valve prolapse, murmur)
 - Does your child have a heart murmur?
 - PreMed needed before dental appointments (antibiotics,etc.)
 - Serious illness/major surgery
 - Radiation/chemo treatment
 - Cancer

- Yes No**
- Blood disorders (anemia, leukemia, etc.)
 - Bleeding abnormally long
 - HIV / AIDS
 - Hepatitis Type ____
 - Stomach problems
 - Kidney problems
 - Liver problems
 - Back problems
 - Diabetes
 - Nervous disorder (cerebral palsy, etc.)
 - Mental disorder
 - Seizures
 - Fainting/dizzy spells
 - Epilepsy
 - Behavioral/Learning difficulties
 - ADD/ ADHD
 - Respiratory problems
 - Asthma
 - Emphysema
 - Tuberculosis (TB)
 - Frequent Headaches or migraines

- Yes No**
- Sinus trouble/ pain
 - Pain or difficulty when chewing
 - Ear stuffiness
 - Ringing in the ears
 - Pain or pressure behind eyes
 - Under physician's care
 - Taking any medications/ supplements (please list below)
 - Allergies to medications** (penicillin, codeine, amoxicillin, aspirin, erythromycin, latex,etc.)
 - Sensitivity to latex or metals
 - Have you been told to give your child antibiotics before dental visits?**
 - Is there anything else we should know about your child's health that we have not covered in this form?**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I also certify that I have received the Dental Materials Fact Sheet and the Privacy Notice.

PATIENT/GUARDIAN DATE

DENTIST SIGNATURE DATE

Please list all medications your child is currently taking:



CHILD HEALTH HISTORY