Heim & Carroll DMD LLC | Dental History

Is this the patient's first visit to the dentist? ☐ Yes ☐ No If no, when was the last visit? _____

Name of previous dentist: _____ Phone No.: _____

Please describe patient's dental problem(s): _____

_____

Please check any of the following that may describe the patient's attitude towards dentistry:
☐ Cooperative ☐ Friendly ☐ Anxious ☐ Shy ☐ Uncooperative

Does the patient have any of the following habits?			Are you concerned?		Other *(Please specify)*:
	Yes	No	Yes	No	_____
Bottle use	☐	☐	☐	☐	
Nail biting	☐	☐	☐	☐	_____
Thumb/finger sucking	☐	☐	☐	☐	
Pacifier sucking	☐	☐	☐	☐	_____
Teeth grinding	☐	☐	☐	☐	
Cheek/lip biting	☐	☐	☐	☐	_____
Jaw clenching	☐	☐	☐	☐	
Mouth breathing	☐	☐	☐	☐	_____
Cavities	☐	☐	☐	☐	

Yes No

☐ ☐ Has the patient had any unhappy dental experience?

☐ ☐ Has the patient had local anesthesia (Novocain)? If yes, were there any problems? _____

☐ ☐ Does the patient brush his/her teeth? If yes how often? _____

☐ ☐ Do you assist in brushing the patient's teeth? If yes how often? _____

☐ ☐ Does the patient use dental floss?

☐ ☐ Does the patient use fluoride in any form? *Please specify:* ☐ Tablets ☐ Drops ☐ Water ☐ Gel/Paste ☐ Rinse

☐ ☐ Does the patient have sugar snacks? *If yes, how often?* _____ times a day _____ times a week
(e.g. raisins, fruit rollups, candy, etc.)

☐ ☐ Does the patient drink soda and/or juice? *If yes, how often?* _____ times a day _____ times a week

☐ ☐ Have you had water tested for Fluoride?

Is there anything else we should know regarding the patient's dental health?

_____

_____

Parent/Guardian Signature: _____ Date: _____ Doctor's Initials _____

Heim & Carroll DMD LLC | Medical History

Name: _____ Date of Birth: _____

Parent or Guardian Name: _____ Phone No.: _____

Child's Physician: _____ Phone No.: _____

Address: _____

Date of Last Physical Exam: _____

Yes	No	
☐	☐	Is patient in good health?
☐	☐	Has patient ever had health problems/been hospitalized? Reason/date: _____
☐	☐	Is patient currently taking medication? If yes, specify: _____
☐	☐	Have you ever been told that patient needs antibiotics before dental treatment?
☐	☐	Does patient have any food allergies? If yes, specify: _____
☐	☐	Does patient have any allergies to medication? If yes, specify: _____
☐	☐	Is patient allergic to latex?
☐	☐	Does patient have any other allergies? If yes, specify: _____
☐	☐	Is patient current with immunizations?

Does patient have or has patient ever had the following conditions?

	Yes	No		Yes	No		Yes	No
Arthritis	☐	☐	HIV Infection	☐	☐	Orthopedic Problems	☐	☐
Asthma	☐	☐	Tuberculosis	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Anemia	☐	☐	Leukemia	☐	☐
GI Disorder	☐	☐	Bleeding (Prolonged)	☐	☐	Fainting/Headaches	☐	☐
Heart Disease	☐	☐	Hemophilia	☐	☐	Gag Reflex	☐	☐
Kidney Disease	☐	☐	Brain Injury	☐	☐	Sleep Apnea	☐	☐
Rheumatic Fever	☐	☐	Cerebral Palsy	☐	☐	Sleep Problems	☐	☐
ADHD	☐	☐	Cleft Lip/Palate	☐	☐	Snoring	☐	☐
Anxiety/Nervousness	☐	☐	Developmental Delay	☐	☐			
Autism	☐	☐	Eating Problems	☐	☐	Other (please specify): _____		
Emotional Disability	☐	☐	Growth Problems	☐	☐	_____		
Learning Disability	☐	☐	Seizures	☐	☐			
Behavior Issues	☐	☐	Speech Problems	☐	☐	_____		
Psychiatric Care	☐	☐	Hearing Loss	☐	☐			
Hepatitis	☐	☐	Neuromuscular Defect	☐	☐	_____		

Parent/Guardian Signature: _____ Date: _____ Doctor's Initials _____