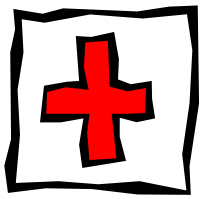
DENTAL HISTORY

Has your child been to the dentist before? **Y N**
If yes, what is the approximate date of last visit? _____
Are there any dental concerns that you would like to discuss?
_____
_____

Does your child brush his/her teeth daily? **Y N**

Please rate your child's oral health __ **Good** __ **Fair** __ **Poor**

Does your child require antibiotics before dental care? **Y N**



MEDICAL HISTORY

Name of child's physician _____

Date of last visit_____ Reason _____

Is your child allergic to any medications? **Y N**

If yes, please list _____

Is your child allergic to latex? **Y N**

Is your child being treated for any medical conditions? **Y N**

If yes, please explain _____