ELITE SMILES
DENTAL LTD

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Dental History

Comments

1. Is this the child's first visit to a dentist?.................................... Yes No
2. Does the child snore? .... Yes No
3. Does the child grind teeth? .... Yes No
4. Are there issues with the tonsils (such as enlarged)? .... Yes No
5. Does the child have any habits such as pacifier / thumb / finger sucking? .... Yes No
6. Does the child have a bottle or sipper cups or speech issues? . Yes No
7. Do you live in an area without fluoridated water? .... Yes No
8. Has the child had any unfavorable dental experiences? .... Yes No

   Explain ____

   ____

Medical History

1. Is the child in good health? .... Yes No
2. Is the child receiving any medication? .... Yes No

   What ____

   When ______________________ Why ______________________
3. Has the child had any serious illness? .... Yes No

   When? ____
4. Has the child had surgery? .... Yes No
5. Is the child subject to profuse bleeding? .... Yes No
6. Is the child subject to nervous disorders? .... Yes No

   Fainting? .... Yes No

   Dizziness? .... Yes No