WHITE BIRCH ORAL SURGERY
CHILD MEDICAL HISTORY

Patient's Name: ____
Last First Initial DOB

Parent/Guardian Name: ____

CIRCLE THE APPROPRIATE ANSWER

DENTAL HISTORY:

1. Is this the child's first visit to a dentist? ……………………………. YES NO
   If not how long since the last visit to the dentist?............................. YES NO
2. Have any teeth been removed by extraction? ……………………… YES NO
3. Was it suggested that the space be maintained?............................... YES NO
4. Was an appliance placed? ………………………………………….. YES NO
5. Have there been any injuries to teeth (chips,blows, falls etc)? ……. YES NO
   If so please describe______________________________
6. Has the child had any unfavorable dental experiences? …………… YES NO
7. How many children in your family?____________________
8. Has anyone in the family had orthodontics?....................................... YES NO
9. Has the child ever received a local anesthetic or any form ………… YES NO
   of anesthetic?
10. Has the child ever had occlusal sealants? …………………………... YES NO

MEDICAL HISTORY:

1. Is the child in good health? ………………………………………….. YES NO
2. Is the child under the care of a physician? If yes , since when?_____
   Why?____
3. Name of physician ____________________________________
4. Is child receiving any medication? When?___________________
5. Has the child had any serious illness? When?_________________
   Why?____
6. Is the child allergic to pencillin,antibiotics or other drugs? ………… YES NO
7. Does the child have any other allergies? …………………………… YES NO
8. Has the child had surgery? ………………………………………….. YES NO
9. Is surgery contemplated? …………………………………………… YES NO
10. Is the child subject to profuse bleeding? …………………………… YES NO
11. Is the child subject to nervous disorder? …………………………… YES NO
12. Fainting? ………………………………………………………….. YES NO
13. Dizziness? ………………………………………………………… YES NO
14. Has the child had history of : diabetes,heart trouble,asthma,
    kidney infection,rheumatic fever, toothache,ear infection or
    any other medical condition?... YES NO

COMMENTS:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Parent/Guardian Signature:____ **Date**_________

Doctor's Signature: ____ **Date**_________