LEGACY DENTAL
Post Falls

Patient Name_____
Name & Relationship of person filling out this form_____
Date of Birth _____
Today's Date _____

Please list any of your child's physicians that they see at least once a year:
NAME SPECIALTY
_____
_____
_____

Are you eligible for any of the following government programs?
WIC Head Start Medicaid SCHIP

Please list any history of hospitalization or surgery and the date: _____

_____

YES NO Do you consider your child to be in good health?
YES NO Is your child up to date on immunizations?

Do your child **currently have** or **ever had**:

YES NO Allergic reactions to: Latex Penicillin Codeine Local Anesthetics Metals Other: _____
Reaction: _____
YES NO Lactose Intolerance or Food allergy
YES NO Heart Conditions including: stent, artificial heart valve, rheumatic heart disease or congenital heart defect

YES NO Irregular Heartbeat
YES NO Cystic Fibrosis
YES NO Complications before or during birth
YES NO Any inherited condition
YES NO Diabetes Type I or Type II
YES NO Jaundice, Hepatitis or liver problems
YES NO Bleeding or clotting disorder
YES NO Sinusitis, chronic adenoid/tonsil infections
YES NO Developmental or intellectual disorders

YES NO High Blood Pressure
YES NO Immunosuppressive condition/treatment
YES NO GERD or acid reflux
YES NO Bladder or Kidney Problems
YES NO Seizures or any other nervous system disease
YES NO Artificial implants or devices
YES NO Sleep Apnea, snoring, mouth breathing
YES NO Asthma
YES NO Impairment of hearing or sight or speech

YES NO Cancer Type_____
Chemotherapy (dates) _____ Radiation (dates) _____

YES NO Physical, behavioral, emotional, sensory or other condition that may require special care
YES NO History of Abuse (physical, psychological, emotional or sexual) or neglect
YES NO Does your child have any disease, condition, or problem not listed here?

For any positive answer above that needs more description, use the space below:

_____
_____
_____
_____
_____
_____

Dental History
What is your primary concern about your child's oral health? _____

If you could wave a magic wand and have one wish granted for your child's oral health, what would it be:

_____

Does your child **currently have** or have they **ever had** any of the following:
YES NO Injury to face or jaw
YES NO Lumps or sores inside the mouth
YES NO Cold sores or canker sores Location:_____ How many times/year?_____
YES NO Bleeding gums
YES NO Grinding or gritting of teeth
YES NO Pacifier or finger/thumb sucking habit beyond 1 year of age

How often do you brush your child's teeth? _____ times per _____
How often do you floss your child's teeth? _____ times per _____

Which of the following do you use to clean your child's teeth? Fluoride Toothpaste Fluoride-Free Toothpaste Other_____

Who cleans your child's teeth? Parent Child Caregiver Other: _____

Who takes care of your child? Circle all that apply:
Mother Father Grandparent Sibling(s) Daycare Nanny Babysitter Other

Have any of the following had cavities in the past year? Circle any that apply:
Mother Father Grandparent Sibling(s) Frequent Caregiver

YES NO Does your child take fluoride supplements?
YES NO Does your child ever go to sleep with a bottle or sippy cup containing anything but water? Contents: _____

YES NO History of Dental treatment? Describe: _____

Dietary Evaluation:
What does your child snack on? _____

What does your child drink between meals? _____

What does your child drink out of? _____

Please list all medicines and supplements that your child is currently taking:

Date	Medicine or Supplement	Dose	Medical Condition	Date Discontinued	Notes

No persons outside of Avondale Dental Group will be provided this information unless properly authorized by you or required by law. By signing below, you agree that the information given is accurate to your knowledge and that you will notify us of any changes at subsequent appointments.

Signature: _____ Date:_____

Relationship to patient:_____