

Has the child ever had a serious/difficult problem associated with previous dental work?  Yes  No If Yes \_\_\_\_\_

Is the child under a physician's care now?  Yes  No If Yes \_\_\_\_\_

Has the child ever been hospitalized or had a major operation?  Yes  No If Yes \_\_\_\_\_

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD)?  Yes  No If Yes \_\_\_\_\_

Is the child's water fluoridated?  Yes  No Is the child taking fluoridated supplements?  Yes  No

Does the child brush their teeth daily?  Yes  No Floss Daily?  Yes  No

Is the child taking any medications, pills, or drugs?  Yes  No If Yes \_\_\_\_\_

Has the child ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates?  Yes  No If Yes \_\_\_\_\_

Is the child allergic to any of the following:  Latex  Metals/Nickel  Plastic Additional allergies \_\_\_\_\_

Does/did the child have any of the following? **Check all that apply.**

AIDS/HIV Positive		Cancer		Hearing Impairment		Leukemia	
ADD/ADHD		Congenital Heart Defect		Heart Murmur		Rheumatic/Scarlet Fever	
Abnormal Bleeding		Convulsions/Epilepsy		Hemophilia		Sickle Cell Disease	
Artificial Bones/Joint		Diabetes		Hepatitis		Tonsillitis	
Asthma		Handicaps/Disabilities		Kidney/Liver Problems		Tuberculosis	

Has the child had any serious illness not listed?  Yes  No If Yes \_\_\_\_\_

Does/did the child experience any of the following? **Check all that apply.**

Lip Sucking/Biting		Thumb/Finger Sucking		Nail Biting		Speech Problems	
Tongue Thrust		Mouth Breather		Clenching/Grinding Teeth		Nursing Bottle Habits	

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform **Gibbs Dentistry** of any changes in my child's medical status. I authorize **Gibbs Dentistry** to perform the necessary dental services my child may need.

Signature of Patient, Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

The Parent/Guardian who accompanies the child is responsible for payment at time of service unless prior arrangement have been approved by **Gibbs Dentistry**.