WELCOME TO

COMFORT KiDS Comfort dental

ABOUT YOUR CHILD

Child's Name _____ Age_____ Birthday _____

Prefers to be called _____ ☐ Male ☐ Female

Reason for visit _____

Referred to this office by (We wish to thank them) _____

DENTAL HISTORY

Child's First Dental Visit? . . . . . ☐ Yes ☐ No

Your child's previous dentist _____

Name City Date of last visit

Date of last dental x-rays _____

Any injuries to you child's teeth or mouth? . . . . . ☐ Yes ☐ No

If yes, please explain _____

Has your child had a history of:

Breast feeding after 1 yr old. . . . . ☐ Yes ☐ No

Bottle habits . . . . . ☐ Yes ☐ No

Thumb sucking/finger sucking . . . . . ☐ Yes ☐ No

Pacifier . . . . . ☐ Yes ☐ No

Dental grinding or clenching . . . . . ☐ Yes ☐ No

Has your child had recent dental pain? . . . . . ☐ Yes ☐ No

If yes, please explain _____

Has your child had any unfavorable dental experiences? . . . . . ☐ Yes ☐ No

If yes, please explain _____

MEDICAL HISTORY

Is your child presently under the care of a physician for any medical reason? . . . ☐ Yes ☐ No

If yes, please explain _____

Is your child presently taking any medications? . . . . . ☐ Yes ☐ No

If yes, what and how much? _____

Does your child have any drug, food, or environmental allergies? . . . . . ☐ Yes ☐ No

If yes, what? _____

Has your child ever been hospitalized or had surgery? . . . . . ☐ Yes ☐ No

If yes, please explain _____

Has your child had any history or difficulty with the following? If so, please check ☑

☐ Heart	☐ HIV	☐ Anemia	☐ Mononucleosis	☐ other _____
☐ Lungs	☐ Asthma	☐ Hepatitis	☐ Cerebral Palsy	
☐ Liver	☐ Fainting	☐ Epilepsy	☐ Rheumatic Fever	
☐ Kidney	☐ Diabetes	☐ Convulsions	☐ Speech problems	
☐ Bladder	☐ Mumps	☐ Tuberculosis	☐ Chronic Sinusitis	
☐ Hearing	☐ Measles	☐ Malignancy	☐ Cleft lip or Palate	

Please Explain _____

I certify that the above information is true and correct to the best of my knowledge.

Signature _____ Relationship to Child _____ Date _____