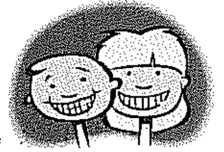
RETURN TO SCHOOL NURSE

Healthy Smiles, Happy Kids
Mobile Dental Van



PATIENT INFORMATION AND HEALTH HISTORY

Please Print and Complete this Form in INK

PERSONAL Information

Patients Full Name ______________________ Sex ____ Child's School ______________________

Address ______________________ School District ______________________ Grade ______

City ______________ State: ______ Zip ________ Date of Birth ____/____/____ Social Security # ______________

Parents/Guardian ______________________ E-mail ______________________

Home Phone ______________ Work Phone ______________ Cell phone ______________

Emergency Contact ______________ Relationship ______________ Phone# ______________

DENTAL History

Has your child ever been to a dentist before? ____ Yes ____ No
When was your child's last check-up and cleaning? ______________ X-Rays? ______________
What was your child's previous dentist's name and address ______________________
Were there any special problems associated with any previous dental visits? If yes, then what? ______________
What is your child's attitude toward the dentist ____ frightened ____ nervous ____ neutral

MEDICAL History

	Y	N
1. Is your child presently in good health?	___	___
2. Is your child presently under a physician's care?	___	___
a. If yes, why? ______________	___	___
3. Is your child presently taking any Medicines?	___	___
a. If yes, what? ______________		
4. Does your child have any allergies to:		
a. Antibiotics (please list) ______________		
b. Aspirin	___	___
c. Codeine	___	___
d. Latex	___	___
e. Dairy	___	___
f. Seasonal (pollen, etc.)	___	___
5. Has your child ever experienced an unfavorable reaction to medicine? If yes, what? ______________		
6. Does your child have/had a heart murmur, rheumatic fever, or a shunt? (please circle which one) Is antibiotic coverage needed for dental?	___	___
7. Does your child have any specific medical condition? (cancer, cerebral palsy, mental retardation, etc.) ______________		
8. Has your child ever had a history of:		
a. Asthma	___	___
b. Hepatitis (A, B or C)	___	___
c. HIV/AIDS	___	___
d. Diabetes (type I or II)	___	___
e. Kidney or liver disease	___	___
f. Tuberculosis	___	___
g. Bleeding disorders	___	___
h. Anemia	___	___
i. Chicken pox	___	___
j. Measles	___	___
k. Seizures	___	___
l. High blood pressure	___	___
m. Speech problems	___	___
n. Learning disabilities (ADHD, ADD, etc.)	___	___
9. Has your child ever had bleeding gums?	___	___
10. Does your child have a history of:		
a. Thumb/finger sucking	___	___
b. Mouth breathing	___	___
c. Grinding teeth	___	___
11. Does your child take dietary fluoride? (tablets or drops)	___	___
12. Does anyone in the household smoke?	___	___

13. Is there any other information which you think we should know:
____
____

14. Do you have any special concerns about your child's mouth?
a. if yes, what? ______________________

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT.

Full Name of Child (please print) ______________________

Full Name of Parent/Legal Guardian (please print) ______________________

Parent/Legal Guardian SIGNATURE ______________________ DATE ______________