Student Dental Health History Form

Student Information

Full Name

Date of Birth

Grade

Address

Parent/Guardian Name

Phone Number

Parent/Guardian Email

Dentist Information

Dentist Name

Date of Last Dental Visit

Dental History

Has the student experienced any of the following? (Check all that apply) ☐ Cavities ☐ Toothache ☐ Gum Problems ☐ Mouth Injury ☐ Braces ☐ None

Describe any current dental concerns

Medical History

Has the student ever had any of the following? (Check all that apply) ☐ Allergies ☐ Asthma ☐ Diabetes ☐ Heart Conditions ☐ Bleeding Disorders ☐ Other ☐ None

If yes to any, please provide details

Is the student currently taking any medications?

Consent & Signature

Consent to treatment

Parent/Guardian Signature

Date