Pediatric Dental Health History Form

Patient Information

Child's Name

Date of Birth

Gender

Parent/Guardian Name

Contact Number

Address

Medical History

Child's Physician

Physician Phone

Any known medical conditions?

Allergies (medications, foods, etc.)

Current medications

Past hospitalizations or surgeries

Dental History

Previous Dentist

Date of Last Dental Visit

Any dental concerns?

Oral habits (thumb sucking, pacifier, etc.)

History of dental injury?

How often does your child brush teeth?

How often does your child floss?

Additional Information

Anything else we should know?