ORAZIO DENTAL

Patient Name: ______________________

Date: ______________________

Child Dental & Medical History

Thank you for filling out this form thoroughly and truthfully. The info you provide will inform and guide our care for your health & safety.

DENTAL HISTORY & SYMPTOMS

Reason for today's visit:

When was patient's last dental exam? dental x-rays? dental cleaning?

Name of most recent dental provider:

Please mark an "X" in the box ONLY if the following applies to the patient:

Hurts to chew, bite or swallow	☐	Trouble with teeth coming in or with losing teeth	☐
Clench or grind teeth	☐	Active/history of pacifier or sucking thumb/finger(s)	☐
Jaw clicks, pops or is painful	☐	Gums bleed or have pain when brushing or flossing	☐
Frequent headaches, neck or ear pain	☐	Anxiety with dental appointments	☐
Teeth bothered by cold or hot temperatures	☐	Traumatic dental experiences	☐
Play contact sports	☐	Suspect or have been diagnosed w/sleep-disordered breathing	☐
Have had or currently in orthodontic treatment	☐	Have had serious injury OR surgery to head or mouth	☐
Currently wear orthodontic retainer	☐		
Dissatisfied with the appearance of smile Please explain:	☐	Please add anything else you feel is important:	

How often are the patient's teeth brushed?

Use of an electric toothbrush?

Does the patient use fluoride toothpaste?

Is your home water supply fluoridated?

Does the patient take fluoride supplements? (drops or chewable tablet)

ALLERGIES & INTOLERANCES

Please mark an "X" in the box ONLY for those that apply to the patient:

Aspirin	☐	Latex	☐
Codeine or other narcotics	☐	Metals / Jewelry	☐
Dental anesthetics	☐	Penicillin or other antibiotics	☐
Gluten	☐	Sulfa drugs / erythromycin	☐
Hay fever / Seasonal allergies	☐	Sulfites	☐
Iodine	☐	Other – Please list:	☐

MEDICATIONS & OTHER SUBSTANCES

Please use an "X" to mark answers to the following questions:

	Yes	No
Does patient use *any form* of **tobacco or nicotine** products? In what form and how often:	☐	☐
Does patient use **vaping** products?	☐	☐
Does patient use **marijuana**? In what form and how often:	☐	☐
Does patient use **controlled substances** or have a history of abuse? Please explain:	☐	☐
Does patient take any other **prescription or over-the-counter medication, vitamins, herbs or supplements?** **Please list:**	☐	☐

MEDICAL & SURGICAL HISTORY		
Date of last physical exam:		
Primary Care Doctor's Name: Phone number:		
Please use an "X" to mark answers to the following questions:	Yes	No
Is patient in good physical health?	☐	☐
Is patient currently being treated for an active health concern? If so, what?	☐	☐
Has patient had a **serious illness, operation or been hospitalized**?	☐	☐
Has patient had an **organ or bone marrow/stem cell transplant**?	☐	☐
Has patient been vaccinated for **Human Papillomavirus/HPV**? (Age 11-12 or beyond)	☐	☐
If you answered yes to any of the above, please explain:		

***Note: It is important for doctor, guardian and patient to communicate honestly about the patient's overall health before dental treatment begins. Many conditions have oral implications that are uncommonly known and important to review.**

My guardian or myself has answered the above questions completely, accurately and to the best of our ability.

SIGNATURE of Patient/Legal Guardian: Date:

Space below is reserved for documentation of updates/changes at future visits.	