FIREFLY CHILDREN & FAMILY ALLIANCE

DENTAL HISTORY

I. CHILD'S HISTORY:

NAME: (last) (first) (middle)

(nickname) (date of birth) (place of birth)

(Attends what school) (grade)

II. DENTAL HISTORY:

	YES/NO
Date of last visit to a dentist	
For what service	
Reason for referral	
Has child complained about dental problems?	☐☐
Any unhappy dental experiences? Explain:	☐☐
Any injuries to mouth-teeth-head? Explain:	☐☐
Any mouth habits-thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. (circle)	☐☐
Any other pertinent information?	☐☐
Any lost teeth? Explain:	
Have missing teeth been replaced?	☐☐
Orthodontic appliances worn now or ever been? Explain:	☐☐

	YES/NO
Have missing teeth been replaced?	☐☐
Orthodontic appliances worn now or ever been? Explain:	☐☐
Do you assist child with tooth brushing?	☐☐
How often?	☐☐
Is dental floss used? How often?	☐☐
Is your drinking water fluoridates?	☐☐
Child's attitude to dentistry: Explain:	☐☐
Is your drinking water fluoridates?	☐☐
Do you desire complete dental service for the child?	☐☐
Do you want your child to have straight teeth?	☐☐
Any unusual speech habits? Explain:	☐☐

III. MEDICAL HISTORY:

HAS CHILD ANY HISTORY OF/OR DIFFICULTY WITH ANY OF THE FOLLOWING?

__ Anemia	__ Chronic Sinus	__ Hearing	__ Mastoid	__Rheumatic Fever
__ Asthma	__ Convulsions	__ Heart	__ Measles	__ Thyroid
__ Bladder	__ Diabetes	__ Kidney	__ Mononucleosis	__ Tuberculosis
__Cerebral Palsy	__ Epilepsy	__ Liver	__ Mumps	__ HIV, ARC or Aids
__ Chicken Pox	__ Fainting	__ Malignancies	__ Hepatitis	__ Other
__Ears	__ Jaundice	__ Hemophilia	__ Mental Retardation	__ Fevers

I understand that the information I provide on this form is essential to determine my child's dental need and the provision of dental treatment: I understand that if any change occurs in my child's health, I am to report it to the dental office as soon as possible.

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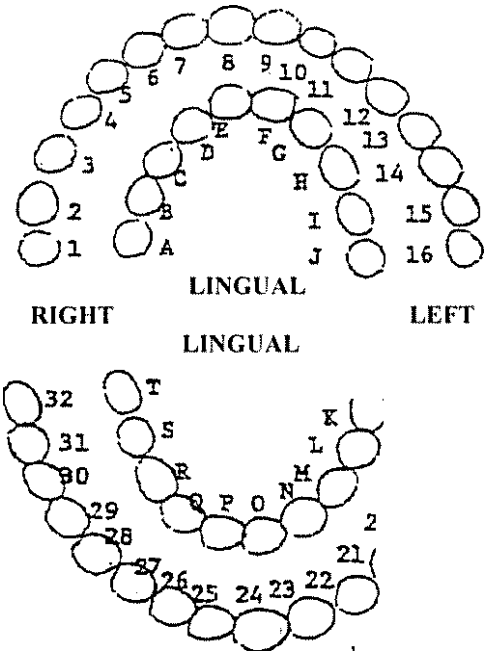
CHILD'S DENTAL REPORT

SEND REPORT TO:_____ Child Name:_____

_____ Date of Birth:_____

_____ Treatment Date: _____

UPPER LABEL



DIAGNOSIS

- ☐ Dental Caries
- ☐ Dental Fracture
- ☐ Gingivitis
  - ☐ Mild
  - ☐ Acute
  - ☐ Chronic
- ☐ Malocclusion
- ☐ Missing Teeth

TREATMENT

- ☐ Exam
- ☐ X-rays
- ☐ Prophylaxis
- ☐ Amalgam or other filing
- ☐ Crowns
- ☐ Gingival Curettage or Therapy
- ☐ Root Canal

OTHER TREATMENT:_____

_____

NEXT APPOINTMENT:_____

OTHER DIAGNOSIS:_____

_____ _____

ATTENDING DENTIST OR PHYSICIAN