

**CHILDREN'S BUREAU, INC.
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		YES/NO
Date of last visit to a dentist _____		Have missing teeth been replaced? _____	<input type="checkbox"/> <input type="checkbox"/>
For what service _____		Orthodontic appliances worn now or ever been? Explain: _____	<input type="checkbox"/> <input type="checkbox"/>
Reason for referral _____		Do you assist child with tooth brushing? _____	<input type="checkbox"/> <input type="checkbox"/>
Has child complained about dental problems? _____	<input type="checkbox"/> <input type="checkbox"/>	How often? _____	<input type="checkbox"/> <input type="checkbox"/>
Any unhappy dental experiences? Explain: _____	<input type="checkbox"/> <input type="checkbox"/>	Is dental floss used? How often? _____	<input type="checkbox"/> <input type="checkbox"/>
Any injuries to mouth-teeth-head? Explain: _____	<input type="checkbox"/> <input type="checkbox"/>	Is your drinking water fluoridates? _____	<input type="checkbox"/> <input type="checkbox"/>
Any mouth habits-thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. (circle) _____	<input type="checkbox"/> <input type="checkbox"/>	Child's attitude to dentistry: Explain: _____	<input type="checkbox"/> <input type="checkbox"/>
Any other pertinent information? _____	<input type="checkbox"/> <input type="checkbox"/>	Is your drinking water fluoridates? _____	<input type="checkbox"/> <input type="checkbox"/>
Any lost teeth? Explain: _____		Do you desire complete dental service for the child? _____	<input type="checkbox"/> <input type="checkbox"/>
Have missing teeth been replaced?	<input type="checkbox"/> <input type="checkbox"/>	Do you want your child to have straight teeth? _____	<input type="checkbox"/> <input type="checkbox"/>
Orthodontic appliances worn now or ever been? Explain: _____	<input type="checkbox"/> <input type="checkbox"/>	Any unusual speech habits? Explain: _____	<input type="checkbox"/> <input type="checkbox"/>

III. MEDICAL HISTORY:

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

- | | | | | |
|---|--|---------------------------------------|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mumps | <input type="checkbox"/> HIV, ARC or AIDS |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> 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.

**CHILDREN'S BUREAU, INC.
CHILD'S DENTAL REPORT**

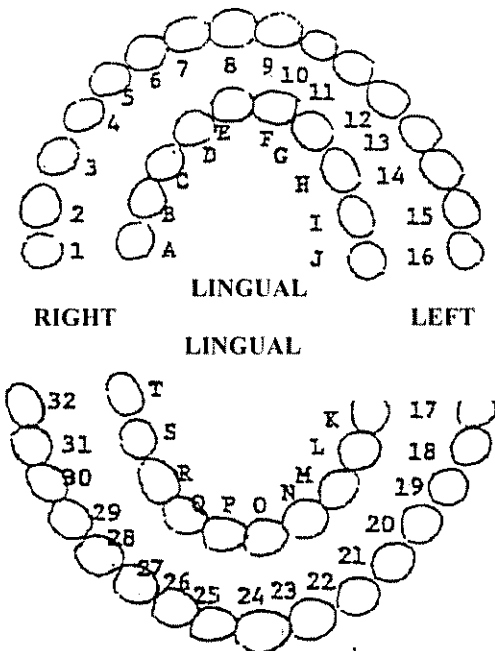
SEND REPORT TO: _____

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 filling
- Crowns
- Gingival Curettage or Therapy
- Root Canal

OTHER TREATMENT: _____

NEXT APPOINTMENT: _____

OTHER DIAGNOSIS: _____

ATTENDING DENTIST OR PHYSICIAN