

## B. CHILD'S DENTAL HISTORY

- |   | Circle answer |
|---|---------------|
| 1. Does your child brush daily?.....  | Yes No        |
| 2. Does your child use floss?.....  | Yes No        |
| 3. Has your child ever had problems with the local anesthesia?.....                 | Yes No        |
| 4. Has your child ever had problems with prior dental treatment?.....               | Yes No        |
| 5. Does your child's gums bleed easily?.....  | Yes No        |
| 6. Does your child have any toothaches or dental problems at the present time?..... | Yes No        |
| 7. When was your child's last dental check-up? _____                                |               |

Please explain all "yes" answers: \_\_\_\_\_  
\_\_\_\_\_

## C. AUTHORIZATION

To the best of my knowledge, I have answered every question completely and accurately. I understand it will be held in the strictest of confidence and it is my responsibility to inform the Department of Public Health and Social Services (DPHSS) Dental Section of any changes in my child's medical status and/or medication. I authorize the DPHSS Dental Staff to perform the necessary dental services for my child.

\_\_\_\_\_  
PARENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_  
DATE

\*\*\*\*\*DO NOT WRITE BELOW\*\*\*\*\*

## D. HISTORY REVIEW

History Reviewed by the Dentist (Dentist's initials) \_\_\_\_\_ Date \_\_\_\_\_

## E. UPDATE (Completed at follow-up visits)

No changes in patient's health since last dental visit.    Initials \_\_\_\_\_ Date \_\_\_\_\_  
No changes in patient's health since last dental visit.    Initials \_\_\_\_\_ Date \_\_\_\_\_