FAMILY Health
DENTAL SERVICES

Dear Parent/Guardian:

We do our best to give your child the best quality dental care in a safe and caring environment. Knowing your child's medical background, medical history, and past dental experiences can be very helpful. We make every effort to work with your child to gain cooperation through understanding, gentle guidance, humor, and charm. Family Health Dental staff wants your child to have a great dental experience. By completing the following, it will help us accomplish our goal.

Thank you for choosing Family Health Dental!

Patient Name: _____ **DOB:** _____

1. Please check any health conditions below your child has or has history of.

Condition/History of:	✓	**Condition/History of:**	✓	**Condition/History of:**	✓
Autism		ADHD		ADD	
Sensory Issues		Special Diet		Speech Delay	
Seizures		Epilepsy		Behavioral Problems	
Developmental Disabilities		Sleep Apnea		Snoring at night	

2. Does your child take any medication for any of the above conditions? ☐ Yes ☐No

3. Has your child been under sedation or general anesthesia? ☐ Yes ☐No

If so, for what reason: _____

4. Has your child had any previous negative dental experiences? ☐ Yes ☐No

If you answered yes:

When? _____

What? _____

5. Does your child have any of the following habit?

☐ **Thumb sucking** ☐ **Finger sucking** ☐ **Pacifier** ☐ **Teeth grinding or clinching** ☐ **Mouth breathing**