BRENTWOOD DENTAL SPECIALISTS, LLC
Alexandra Hendricks, D.M.D.
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DENTAL HISTORY

Is this your child's first ever dental visit? Yes No If no, when was the child's last visit? _____

When were the last dental xrays taken? _____ Any unfavorable dental experiences? Yes No _____

If yes. please explain _____

Have there been any injuries to teeth such as falls, blows or chips? Yes No If yes, what? _____

Has your child received any orthodontic treatment? Yes No If yes, what? _____

How would you describe your child's temperament? _____

MEDICAL HISTORY

Is the child under a physicians care? Yes No If yes, for what? _____

Is your child taking any medications? Yes No Medication and Dose: _____

Why does the child have to take it? _____

Family Physician Name _____ Phone Number _____

Is the child allergic to **PENICILLIN**? Yes No Is the child allergic to **LATEX** (ie, gloves)? Yes No _____

Any other known allergies? Yes No If yes, what? _____

Has the child ever been hospitalized for illness/injury? Yes No If yes, what? _____

Has the child had any history of: (Circle the appropriate response)

Asthma	Breathing Problems	Blood Disease	Behavior Problems	Cancer	Diabetes
Epilepsy	Ear Infections	Heart Trouble	Kidney Problems	Liver Problems	Seizures
Tumors	Developmental Delay	Autism	HIV Positive	Anemia	Hemophilia

Other: _____

Does the child require antibiotics as recommended by the physician before dental treatment (i.e. heart conditions, low white blood cell count)? Yes No

IF YES, WE REQUIRE A LETTER FROM THE PHYSICIAN STATING THIS REQUIREMENT BEFORE TREATMENT CAN BEGIN.

Is the child generally healthy? Yes No If no, why not? _____

I UNDERSTAND ALL APPOINTMENTS MUST BE CONFIRMED TO REMAIN ON THE SCHEDULE.

I would like to confirm appointments via:

Email _____ Text (____)_____ Phone (____)_____

❍ All of the above

My children attend the school district of:_____

Parent/Adult Signature _____ Date _____ Dentists Signature _____