PAUL A. KLOEK, DDS
W7154 Green Valley Road
Spooner, WI 54801
Phone 715-635-7888
greenvalleydentalcare.com

Dental History for Minors

Patient Name: _____ DOB: _____

Parents, please complete this form on behalf of your children 16 years old and younger.

1. Is this your first visit to the dentist? **Yes** **No**
2. How frequently do you brush your teeth?
   ☐ Twice daily ☐ Right after eating ☐ Morning only ☐ Evening Only
3. When brushing your teeth do you also brush your tongue/gums? **Yes** **No**
4. Have any cavities been diagnosed in the past? **Yes** **No**
5. Do you wear a retainer or has one been recommended? **Yes** **No**
   If yes, please describe: _____
6. Do you have any concerns with your mouth/teeth? **Yes** **No**
   If so, please explain:_____
   _____
7. Were any teeth removed by extraction? **Yes, baby teeth** **Yes, adult teeth** **No**
8. Have you ever received local anesthetic? **Yes** **No**
9. Have you ever had occlusal sealants? **Yes** **No**
   Is yes, please describe when/where:_____
10. Have your teeth been traumatized by sport activity or other injury? **Yes** **No**
11. Are you aware of yourself (or your child) snoring? **Yes** **No**
12. Are you aware of grinding, bruxing, or clenching your teeth? **Yes** **No**
13. Are you experiencing pain in your teeth, mouth, or jaw? **Yes** **No**
14. How anxious are you when visiting the dentist?
    not at all anxious 1 2 3 4 5 6 7 8 9 10 **extremely anxious**
15. Do you have well water? **Yes No** Is your water fluoridated? **Yes** **No** **Unsure**
16. Do your gums bleed or cause pain? **Yes** **No**
17. Is there anything else we should know to help provide you with the best care?

_____
_____

Form Continues on Reverse

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Medical History for Minors

Patient Name: _____ DOB: _____

1. Do you currently have any health problems? **Yes** **No**
   If yes, describe: _____
2. Name and phone number of current physician: _____
3. Are you taking any medications? **Yes** **No**
   List: _____
4. Have you ever had surgery or are any surgeries planned? **Yes** **No**
   If yes, describe: _____
5. Do you have a heart murmur or any other heart condition? **Yes** **No**
6. Do you ever experience severe or prolonged bleeding, or have you been diagnosed with anemia? **Yes** **No**
   If yes, describe: _____
7. Do you have a history of nervous disorders? **Yes** **No**
   If yes, describe: _____
8. Have you tested positive for hepatitis? **Yes** **No**
9. Are you allergic or sensitive to any of the following?

☐ **None** ☐ **Codeine** ☐ **Penicillin** ☐ **Local Anesthetic** ☐ **Latex** ☐ **Nuts** (type:_____)

☐ **Other** (please describe): _____

10. Please check if you have, or have had, any of the following:

- ☐ Diabetes
- ☐ Asthma
- ☐ Hay Fever
- ☐ Kidney Infection
- ☐ Liver Problems
- ☐ Hepatitis/Jaundice
- ☐ Thyroid Problems
- ☐ Rheumatic Fever
- ☐ Epilepsy/Seizures/Fainting
- ☐ Cerebral Palsy
- ☐ Cancer
- ☐ Leukemia
- ☐ Oral Herpetic Lesion(s)
- ☐ Eating Disorders
- ☐ Speech Impediments
- ☐ Hearing Impaired
- ☐ Special Needs
- ☐ Take "Pre-medication" prior to dental treatment for any reason

Notes/description on any of the above:

_____

_____

_____

- I attest to the accuracy of the information on this page and understand it is my responsibility to inform the Doctor and GVDC office staff of any changes to my/my child's medical status before any further treatment is rendered.

Patient/Guardian Signature: _____ Date: _____
Dentist's Signature: _____ Date: _____

(Medical History 6 month update ONLY)
Any Changes to Medical History? *Yes* *No*