



**VIRAMONTES SMILE CARE**  
DENTAL HYGIENE PRACTICE

Please complete all questions below. This information helps us provide safe, individualized dental hygiene care for your child.

**CHILD INFORMATION**

**Child's Name:** \_\_\_\_\_  
**Preferred Name:** \_\_\_\_\_  
**Date of Birth / Age:** \_\_\_\_\_  
**Parent / Guardian:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Pediatrician / Physician:** \_\_\_\_\_

**MEDICAL HISTORY**

Is your child currently under the care of a physician for a medical condition? ☐ Yes ☐ No

**If yes, explain:** \_\_\_\_\_

Has your child ever been hospitalized, had surgery, or had a serious illness? ☐ Yes ☐ No

**If yes, explain:** \_\_\_\_\_

Does your child have allergies or sensitivities to medications, foods, latex, or other substances? ☐ Yes ☐ No

**Allergies / reactions:** \_\_\_\_\_

Does your child take prescription or OTC medications, vitamins, supplements, or herbal products? ☐ Yes ☐ No

**Please list:** \_\_\_\_\_

**Has your child ever had, or do they currently have, any of the following?**

|                                                       |                                                            |
|-------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Asthma / breathing problems  | <input type="checkbox"/> Heart condition / heart murmur    |
| <input type="checkbox"/> Bleeding / clotting disorder | <input type="checkbox"/> Anemia / blood disorder           |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Seizures / epilepsy               |
| <input type="checkbox"/> Kidney disease               | <input type="checkbox"/> Liver disease / hepatitis         |
| <input type="checkbox"/> Cancer / immune disorder     | <input type="checkbox"/> Frequent infections               |
| <input type="checkbox"/> Gastric reflux               | <input type="checkbox"/> Sleep apnea / significant snoring |
| <input type="checkbox"/> Premature birth              | <input type="checkbox"/> Developmental delay               |
| <input type="checkbox"/> Autism spectrum disorder     | <input type="checkbox"/> ADD / ADHD                        |
| <input type="checkbox"/> Anxiety / depression         | <input type="checkbox"/> Sensory sensitivities             |
| <input type="checkbox"/> Other medical condition      | <input type="checkbox"/> None of the above                 |

**Please explain:** \_\_\_\_\_

**DENTAL HISTORY**

Is this your child's first dental visit? ☐ Yes ☐ No

**Last dental visit:** \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

Is your child currently experiencing dental pain or discomfort? ☐ Yes ☐ No

**If yes, describe:** \_\_\_\_\_

Has your child ever had an injury to the teeth, mouth, jaw, or face? ☐ Yes ☐ No

**If yes, explain:** \_\_\_\_\_



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ORAL HEALTH & HABITS

|                                                |                                                 |
|------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Bleeding gums         | <input type="checkbox"/> Sensitive teeth        |
| <input type="checkbox"/> Frequent cavities     | <input type="checkbox"/> Bad breath             |
| <input type="checkbox"/> Grinding / clenching  | <input type="checkbox"/> Thumb / finger sucking |
| <input type="checkbox"/> Pacifier use          | <input type="checkbox"/> Mouth breathing        |
| <input type="checkbox"/> Dental anxiety / fear | <input type="checkbox"/> Orthodontic treatment  |

Brushing frequency: \_\_\_\_\_

Flossing frequency: \_\_\_\_\_

|                                                                         |                              |                             |
|-------------------------------------------------------------------------|------------------------------|-----------------------------|
| Does your child use fluoride toothpaste?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your child take a fluoride supplement?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your child regularly drink fluoridated tap water?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your child frequently snack or sip sweetened drinks between meals? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

INFANT / TODDLER - IF APPLICABLE

Was your child born prematurely? ☐ Yes ☐ No

If yes, how many weeks? \_\_\_\_\_

Does or did your child sleep with a bottle or sippy cup? ☐ Yes ☐ No

If yes, contents: \_\_\_\_\_

Is your child currently breastfed or bottle-fed? ☐ Yes ☐ No

SPECIAL CONSIDERATIONS

Please describe any developmental, behavioral, sensory, communication, mobility, or other needs that may help make your child's visit more comfortable and successful.

\_\_\_\_\_  
\_\_\_\_\_

PARENT / GUARDIAN CERTIFICATION

I certify that the information provided is complete and accurate to the best of my knowledge. I will notify Viramontes Smile Care Dental Hygiene Practice of any changes in my child's health, medications, allergies, or medical care.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_