Family Dental of South East Wisconsin, S.C.
Dr. Thomas Casey
Dr. Erin Haugen

GET-ACQUAINTED AND MEDICAL HISTORY QUESTIONNAIRE (For your child)
(CONFIDENTIAL)

Patients Name_____Date of Birth_____

Parents Name_____

Phone Number: Home_____ work_____

Address_____City_____Zip_____

Physician's name_____

Address_____

Whom may we thank for referring you to our office? _____
When was your child last seen by a dentist? _____
How often does your child brush? _____ times a day.
Do you live in an area without fluoridated water? Yes____ No____ Unsure____
Have the teeth been treated with fluorides? Yes____ No____ Unsure____
Has child ever had occlusal sealants? Yes____ No____ Unsure____
Has child had any unfavorable dental experiences? Yes____ No____ Unsure____
Any injuries to teeth such as falls, blows, chips? Yes____ No____ Unsure____
if so, describe_____

Has child ever received a local anesthetic (Novocain) Yes____ No____ Unsure____
Has child ever received local analgesic (Nitrous Oxide)Yes___ No____ Unsure____
Any objections to anesthetic/analgesic? Yes___ No____ Unsure____

Is child under medical care now? Yes____No____ For what? _____
Is child taking any medicine? Yes____No____ What? _____
Is child allergic to any medication? Yes____No____ What? _____
Is child allergic to any food? Yes____No____ What? _____

Does child need to be premedicated with antibiotics before dental procedures for?
any reason? Yes____ No____ If so, what for? _____

Have child ever had, or has now, any of the following:

Yes___No___Rheumatic Fever	Yes___No___Aids/HIV Virus/ARC
Yes___No___Diabetes	Yes___No___Epilepsy/Seizures
Yes___No___Heart Murmur	Yes___No___Heart Trouble
Yes___No___Mental Retardation	Yes___No___Fainting
Yes___No___Prolonged Bleeding	Yes___No___Tumors/Growths
Yes___No___Blood Disease or Anemia	Yes___No___Cancer
Yes___No___Hepatitis/Liver Disease	Yes___No___Blood Transfusions
Yes___No___Kidney Disease/Jaundice	Yes___No___Sinus Trouble/Asthma

Date_____ Parent's Signature_____