

CHILD'S HEALTH HISTORY

TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's name _____

MI _____

Last
Nickname

First

Male Female

Child's Birthdate: _____

School: _____

Child's Home Phone #: _____

SS#: _____

Child's Home Address: _____

Street

City

Zip

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____

Relation: _____

Do you have legal custody of this child? Yes No

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: Single Married Widowed Divorced Separated

Mother's Information:

Name: _____

Work #: _____ Ext: _____

Home #: _____

Employer: _____

SS#: _____ DL#: _____

Father's Information:

Name: _____

Work #: _____ Ext: _____

Home #: _____

Employer: _____

SS#: _____ DL#: _____

Person Responsible for Account

Name: _____

Relation: _____

Billing Address _____

Street

City

Zip

Work #: _____ Ext: _____

Home #: _____

Employer: _____

SS#: _____ DL#: _____

Who is responsible for making appointments?

Name: _____

Work #: _____ Ext: _____

Home #: _____

Primary Dental Insurance

Insurance Co. Name _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate / /

& SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate / /

& SS#: _____

Insured's Employer: _____

WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY?

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO
Is the child's water fluoridated? YES NO
Is the child taking fluoride supplements? YES NO
Has the child ever had any pain or tenderness in their jaw joint (TMJ / TMD)? YES NO
Does the child brush their teeth daily? YES NO
Is the child being treated or has been treated by an orthodontist (braces or retainers)? YES NO

Name of orthodontist

Has your child ever had sealants placed? YES NO

Child's Physician:

Phone #:

Date of Last Visit:

Is the child currently under the care of a physician? YES NO

Please describe the child's current physical health: good Fair Poor

Please list all drugs that the child is currently taking:

Please list all drugs that the child is allergic to:

Has the child ever had any of the following medical problems?

Heart Murmur YES NO Asthma YES NO Hearing Impairment YES NO
Cancer YES NO Hepatitis YES NO Any Operation YES NO
Diabetes YES NO Tuberculosis (TB) YES NO Any stays in a hospital YES NO
Rheumatic Fever YES NO Abnormal Bleeding YES NO Kidney / Liver Problems YES NO
HIV+ / AIDS YES NO Congenital Heart Defect YES NO Handicaps / Disabilities YES NO
Hemophilia YES NO Convulsions / Epilepsy YES NO Allergies to any drugs YES NO

Please discuss any serious medical problems that the child has had:

Does the child have any of the following habits?

Thumb / Finger Sucking / Pacifier YES NO Nail Biting YES NO
Lip Sucking / Biting YES NO Nursing Bottle Habits YES NO

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

If deemed advisable, I grant permission for our physician to be contacted for details and advice. For evaluation or teaching purposes I authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

SIGNATURE OF PARENT OR GUARDIAN

DATE

REVIEWED BY

DATE

OFFICE USE ONLY

Height Weight BP Pulse Age

HEALTH COMMENTS: