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HEALTH HISTORY

Date: ___________ Update: ___________

PERSONAL

Child's Full Name____ Age___________ Birth date_________________
Nickname (if any) ________________________________ Sex _____ Place of Birth ___________________________
What is your child most interested in? ____
Brothers, names and ages ________________________________ Sisters _____________________________________
Is your child adopted? ☐ Yes ☐ No If yes, does your child know? ☐ Yes ☐ No
Child's pediatrician or physician __________________________________ Telephone # ________________________
Who may we thank for referring you? __________________________ Child attends what school? ________________

MEDICAL

Has your child had any of the following medical problems? *Circle Yes (Y) or No (N)* – **discuss below if necessary**

Allergies to drugs or foods	Y N	Ear Infections	Y N	HIV+/AIDS	Y N
Asthma or lung problems	Y N	Handicaps or disabilities	Y N	Operations or Hospital/ER stays	Y N
Blood transfusions	Y N	Heart defect (congenital)	Y N	Learning disabilities	Y N
Cancer	Y N	Heart murmur	Y N	Rheumatic Fever	Y N
Convulsions or epilepsy	Y N	Hemophilia or abnormal bleeding	Y N	Trauma to mouth or face	Y N
Developmental delay	Y N	Hepatitis	Y N	Tuberculosis (TB)	Y N
Diabetes	Y N	High fevers	Y N	Latex Allergy	Y N

Other medical problems: ____
Please discuss problems further, if necessary: ____
____
____
Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics (including the operating room)? Y N
Is your child currently taking any medications (including over-the-counter)? Y N What kind? ____________________
Does your child have any breathing problems? Y N Breathes primarily through nose or mouth? (please circle)
Does your child snore? Y N Does your child have frequent sore throats? Y N

HABITS

Does your child have or had any of the following habits?

Thumb or finger sucking	Y N	Pacifier use	Y N	Nail biting	Y N
Lip sucking or biting	Y N	Biting hard objects	Y N	Tooth grinding	Y N

Did your child use a bottle? Y N If yes, when did he/she stop? ________________________
Does your child currently use a bottle? Y N If yes, how often during the day? ______________________
Is the bottle used at night? Y N What is your child drinking? ________________________
Does your child currently nurse? Y N Does your child nurse at night time? Y N

FAMILY DENTAL HISTORY *(Circle appropriate parent, if yes)*

Has Mother or Father had a lot of decay? Has Mother or Father had orthodontic care?
Does Mother or Father have periodontal disease? Does Mother or Father have TMJ problems?

CHILD'S DENTAL HISTORY

Has your child seen a dentist before? Y N
If yes, the approximate month and year of last visit: ____________ Where? ____________________________
Has your child had any unfavorable experiences in a dental or medical office? Y N ____________________________
Does your child have any dental problems (pain, infection, spacing or orthodontic problems, etc.) presently? Y N
If yes, please explain: ____
How often does your child brush his/her teeth per day? ________ Do you help? Y N
How often does your child floss? __________________________ Do you help floss your child's teeth? Y N
How do you think your child will act today towards the dentist? ____
Purpose of today's dental visit ____

Examining Doctor's Initials ________ Date ___________

(OVER) ⇒

PARENT INFORMATION

FATHER	*MOTHER*
Name ____________________	Name ____________________
Home Address ____________________	Home Address ____________________
____________________	____________________
Home Phone# (___)____________________	Home Phone# (___)____________________
Cell Phone # (___)____________________	Cell Phone # (___)____________________
Employer's Name ____________________	Employer's Name ____________________
Occupation ____________________	Occupation ____________________
Employer's Phone # (___)____________________	Employer's Phone # (___)____________________
Employer's Address ____________________	Employer's Address ____________________
____________________	____________________
DOB__________ Driver's License # ___________	DOB__________ Driver's License # ___________
SS# _____-____-________	SS# _____-____-________
E-mail: ____________________	E-mail: ____________________

Name of Parent/Guardian that child lives with ____________________

Name of Parent/Guardian financially responsible ____________________

Best number to call to remind you of your child's appointment ____________________

In the event of an emergency, whom should we contact?

Name:__________________Relationship:__________________Phone:______________

Name of nearest relative not living with child:__________________Phone:______________

DENTAL INSURANCE:

PRIMARY	*SECONDARY*
Responsible Party ____________________	Responsible Party ____________________
Carrier Name ____________________	Carrier Name ____________________
Carrier Address ____________________	Carrier Address ____________________
____________________	____________________
Carrier Phone # (___)____________________	Carrier Phone # (___)____________________
Group # ____________________	Group # ____________________

I (the parent) understand that the information I provide on this health and information form is essential to determine my child's dental needs and the provision of dental treatment; I understand that if any changes occur in my child's health, I am to report it to the doctor or his staff as soon as possible. I have read and understand each question, I have answered all of them truthfully and to the best of my ability; and I have discussed my child's health history with the doctor.

______________________________ ______________________________

Parent/Guardian Signature Dentist Signature

I authorize the use of radiographs, study models, photographs, and video recordings of my child's treatment for presentations or publications of the doctor.

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Parent/Guardian Signature