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Diplomate, American Board of Pediatric Dentistry

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? Y N Does your child know? Y N

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? *Check 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			

Other medical problems: ____

Please discuss problems further, if necessary: ____

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Has your child had any unfavorable reactions to medications or anesthetics (including the operating room)? Y N

Is your child currently taking any medications? Y N What kind? ____

Does your child have any breathing problems? Y N Breathes primarily through nose or mouth? ___________

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

Has Mother/ Father had a lot of decay? ________________ Has Mother/ Father had orthodontic care? ______________

Does Mother/Father have gum disease?________________ Does Mother/ 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 currently have any dental problems (pain, infection, or orthodontic problems, etc.)? Y N

If yes, please explain: ____

How often does your child brush his/her teeth per day? ________ Do you help brush? Y N

How often does your child floss? __________________________ Do you help floss? Y N

How do you think your child will act today towards the dentist? ____

Purpose of today's dental visit ____

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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.

________________________________ Parent/Guardian Signature