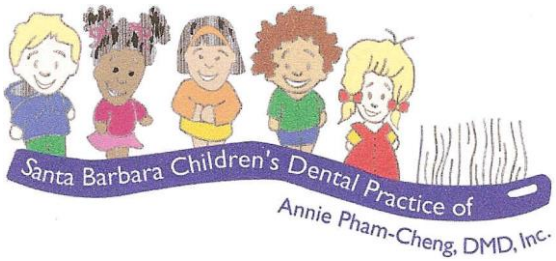

Pediatric Dentistry Health History Form

MEDICAL AND DENTAL HISTORY

Careful completion of this form will assist us in providing your child with the best possible dental care,

Child's Name _____ Date of Birth ____/____/_____

Prefers to be called _____

School_____ Grade_____

Home Address: _____

City _____ Zip _____Phone_____

Mother's Name _____ Occupation _____

Work Address _____ Phone _____

Father's Name _____ Occupation _____

Work Address _____ Phone _____

Legal Guardian(s)_____

Email address (optional) _____

Child's favorite hobbies_____

Names and ages of siblings _____

How did you hear about us_____

INSURANCE INFORMATION

Dental Insurance 1_____ Dental Insurance 2_____

Policy Holder 1 _____ Policy Holder 2_____

Social security number 1 _____ Social Security number 2_____

DOB 1 _____ DOB 2 _____

MEDICAL HISTORY

Child's Physician_____ Phone#_____

Address_____ City_____ State _____

Date of Last Physical Examination_____

Is your child being treated by a physician at this time?..... YES NO

If yes, why?_____

Is your child taking any medications at this time?..... YES NO

If yes, what and why?_____

Has your child ever been hospitalized? ..... YES NO

If yes, why and when?_____

Has your child had any operations?..... YES NO

If yes, why and when?_____

Has your child ever had general anesthesia?..... YES NO

If yes, were there any complications? _____

_____

Is your child allergic to anything? *(Medications, Food, Latex, Metals, Dyes,Other)* ..... .YES NO

If yes, what? _____

Has your child ever been given antibiotics?..... YES NO

If yes, were there any complications?_____

Is your child up to date on his/her immunizations? ..... YES NO

MEDICAL HISTORY

Organs and Systems: Has your child *ever* had any treatment for any of the following? Please check yes or no:

YES	NO		YES	NO	
……	……	Blood – Circulatory	……	……	Heart
……	……	Bones	……	……	Liver
……	……	Endocrine Glands	……	……	Musculoskeletal
……	……	Eyes, Ears, Nose, Throat	……	……	Nervous System
……	……	Gastrointestinal	……	……	Skin
……	……	Kidney / Bladder			

If yes to any of the above, please elaborate._____

_____

_____

Illness: Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

	Yes	No		Yes	No
Anemia	…….	……..	Heart Disease	…….	……
Allergy	…….	……..	Hemophilia	…….	……
Arthritis	…….	……..	Hepatitis-Type……	…….	……
Asthma	…….	……..	Immune Deficiency	…….	……
Autism	…….	……..	Jaundice	…….	……
Brain Injury	…….	…….	Learning Disability	…….	……
Cancer	…….	…….	Leukemia	…….	……
Cerebral Palsy	…….	…….	Mental Retardation	…….	……
Chicken Pox	…….	…….	Nutritional Deficiency	…….	……
Cleft Lip/Palate	……	…….	Orthopedic problems	……	……
Cystic Fibrosis	……	…….	Rheumatic Fever	……	……
Convulsions	……	…….	Scoliosis	……	……
Diabetes	……	…….	Sickle Cell Anemia	……	……
Eye Problems	……	…….	Spina Bifida	……	……
Excess Bleeding	……	…….	Tetanus	……	……
Fainting	…….	…….	Whooping Cough	……	……
Hearing Loss	…….	…….	Other		

DENTAL HISTORY

Is this your child's first dental visit?. ..... YES NO

Reason for bringing child for this visit?_____

_____

Name of child's previous dentist _____Date of last visit_____

Has your child had dental radiographs (x-rays)? .....YES NO

If yes, when were they last taken?_____

Has your child *ever* had local anesthesia? *(*Novocaine).....YES NO

If yes, were there any complications?_____

Has your child ever been sedated or received general anesthesia? .....YES NO

Please indicate if your child has or has had any of the following oral habits:

Breathes through mouth..... YES NO

Sucks thumb or finger ..... YES NO

Uses a pacifier..... YES NO If yes, until what age?_____

Bites or sucks lips..... YES NO If yes, until what age?_____

Tongue habit ..... ;.... YES NO

Bottle to bed ..... YES NO

Other _____ If yes, until what age?_____

Do you live in a community with fluoridated water? ..... YES NO

Does your child drink tap water? ..... YES NO

Does your child use any fluoride supplements? (Rinses, vitamins)..... YES NO

If yes, name of product _____

How often does your child brush his/her teeth?_____

When? _____

Brand of toothpaste? _____

Type of toothbrush: Manual, powered, soft or hard bristles_____

Does your child floss his/her teeth?..... YES NO

When?_____

Is there parental assistance or supervision when:

Brushing?..... YES NO

Flossing? ..... YES NO

History of cavities in the family_____

History of missing or extra teeth_____

Additional remarks_____

THE SIGNATURE OF A PARENT OR GUARDIAN BELOW AUTHORIZES THE INITIAL CHECKUP AND THE FILING OF INSURANCE CLAIMS. YOU WILL BE ASKED TO SIGN SEPARATE INFORMED CONSENTS FOR FURTHER TREATMENTS.

SIGNATURE _____
DATE _____
RELATIONSHIP_____

Please bring this completed form to your child's initial appointment.