Child Health and Dental History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This

Patient's Name: Last, First, Middle	Nickname:	Date of Birth:
Parent's/Guardian's Name:	Relationship to Patient:	Does the patient have dental insurance? Yes ☐ No ☐

Mailing Address: City: State: Zip Code:

Home Phone: Parent's/Guardian's Cell: Parent's/Guardian's Email: Sex: M ☐ F ☐

Do you have any of the following: Active tuberculosis, persistent cough (greater than a 3 week duration), cough that produces blood, or have you been exposed to anyone with tuberculosis? **If you answer yes to any of the items above, please stop and return this form to the receptionist.**

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Tobacco/Drug Use
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tuberculosis
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Seizures	☐ Other _____
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Sickle Cell	
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Thyroid	

Teens: Are you taking birth control? ☐ Yes ☐ No Is there any possibility you could be pregnant? ☐ Yes ☐ No

Please list the name and phone number of the child's physician:

Name of Physician: Phone number:

CHILD'S HISTORY

	Yes	No
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?	☐	☐
If yes, please list: _____		
Is the child allergic to any medications, i.e penicillin, antibiotics, or other drugs? If yes, please explain: _____	☐	☐
Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	☐	☐
How would you describe the child's eating habits? _____		
Has the child ever had a serious illness? If yes, when? _____ Please describe: _____	☐	☐
Has the child ever been hospitalized?	☐	☐
Does the child have a history of any other illnesses? If yes, please list: _____	☐	☐
Has the child ever received a general anesthetic?	☐	☐
Does the child have any inherited problems?	☐	☐
Does the child have any speech difficulties?	☐	☐
Has the child ever had a blood transfusion?	☐	☐
Is the child physically, mentally, or emotionally impaired?	☐	☐
Does the child experience excessive bleeding when cut?	☐	☐
Is the child currently being treated for any illnesses?	☐	☐
Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date: _____	☐	☐
Has anyone ever taken dental x-rays on the child?	☐	☐
Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
Has the child had any problems with the eruption of teeth or with losing teeth?	☐	☐
Has the child had any orthodontic treatment?	☐	☐
What type of water does the child drink? (please check all that apply) City Water ☐ Well Water ☐ Bottled Water ☐ Filtered Water ☐		
Does the child take fluoride supplements?	☐	☐
Is fluoride toothpaste used?	☐	☐
How many times are the child's teeth brushed per day? _____ When are the teeth brushed? Morning ☐ Noon ☐ Evening ☐		
Does the child suck his/her thumb, fingers or pacifier?	☐	☐
At what age did the child stop bottle feeding? _____ Breast feeding? _____		
Does the child participate in recreational activities?	☐	☐

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature: _____ *Date:* _____