Children's Health/Dental History Form

Childs Name: ____

Last First MI

Nickname: ______________ M or F (circle) Birth date: _____/_____/_____ Age: ______

Social Security #: _____-_____-________ Home Phone # (_____) _______- __________

Child's Home Address: ____

____

City State Zip

Person Responsible for Account: _____________________ Relationship: ___________

Mother/Stepmother/Guardian (please circle):

Name: _________________________________ Date of Birth_____/_____/_______

E-Mail: ________________________________ Social Security # ____/____/______

Home Phone # (____) _____-________ Work Phone # (____) _____-_______ Ext _____

Employer:_________________________ Occupation: ________________________

Father/Stepfather/Guardian (please circle): Name:_________________________________

Date of Birth_____/_____/_______

E-Mail: ________________________________ Social Security # ____/____/______

Home Phone # (____) _____-________ Work Phone # (____) _____-_______ Ext _____

Employer:_________________________ Occupation: ________________________

Primary Dental Insurance:

(In order for us to help provide you with accurate Dental Benefit Information please allow us to copy your card)

Insured's Name: __________________________ Relationship:____________________

Date of Birth: _____/_____/________ Social Security # ____/____/______

Insurance Company: _______________________ Group No. ___________________

Member ID ______________________________ Employer: ____________________

Secondary Dental Insurance:

(In order for us to help provide you with accurate Dental Benefit Information please allow us to copy your card)

Insured's Name: __________________________ Relationship:____________________

Date of Birth: _____/_____/________ Social Security # ____/____/______

Insurance Company: ______________________ Group No. ____________________

Member ID ______________________________ Employer: ______________________

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Your child's overall health as well as any medications that your child may take could play an important role in your child's dental treatment. Please answer each of the following questions completely.

Has the child had any history of, or condition related to, any of the following:
(Please circle a Y or N answer for each condition)

Anemia	Y N	Epilepsy	Y N	Rheumatic Fever	Y N		
Arthritis	Y N	Fainting	Y N	Seizures	Y N		
Asthma	Y N	Hearing	Y N	Sickle Cell	Y N		
Blood Disorders	Y N	Heart	Y N	Thyroid	Y N		
Bones/Joints	Y N	Hepatitis		Y N		Tuberculosis	Y N
Cancer	Y N	HIV/AIDS	Y N	Other	Y N		
Cerebral Palsy	Y N	Kidney	Y N				
Chicken Pox	Y N	Latex Allergy	Y N				
Chronic Sinusitis	Y N	Liver	Y N				
Diabetes	Y N	Measles	Y N				
Ear Aches	Y N	Mumps	Y N				

Allergic to: Penicillin, Sulfa, Codeine Acetometaphine, Ibuphrophen

Other: ____________________________

If you answered Yes to any of the above please provide us with any additional information:

____

____

Is the child taking any prescription medications or over the counter medications? ……………………….. Y N

If Yes, please list ____

Has the child ever had a serious illness? If yes, please explain? ______________________________ Y N

Has the child ever been hospitalized? .... Y N

Is the child physically, mentally or emotionally impaired? ………………………………………………… Y N

Is the child currently being treated for any illness? ………………………………………………………... Y N

Is this the child's first visit to the dentist? If not, when was the last visit? _________________________ Y N

Has the child had any problem with dental treatment in the past? ……………………............................... Y N

Has the child ever had x-rays taken before? ………………………………………………………………. Y N

Has the child ever suffered any injury to the head, neck or teeth? ………………………………………… Y N

Has the child had any problems with the eruption or shedding of teeth? ………………………………….. Y N

Has the child had orthodontic treatment? …………………………………………………………………… Y N

Does the child suck his/her thumb, fingers or pacifier? ………………………………………………….. Y N

What type of water does your child drink? (circle) **City Water/Well Water/Bottled Water/Filtered Water**
Does the child take fluoride supplements? ………………………………………………………. Y N
Is Fluoride toothpaste used? ……………………………………………………………………Y N
Is a fluoride rinse used? ....
....Y N

How many times per day are the child's teeth brushed? ______ When are they brushed? __________________

How often are the child's teeth flossed? ____ ___________

Does the child participate in recreational activities? What? _______________________________________ Y N

I certify that I have read and understand the above. I attest under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct. Any omissions that I have made in the completion of this form, I am responsible for.

Parent's/Guardian's Signature: ____ Date: __________

Dr's Signature: ____Date: __________
____