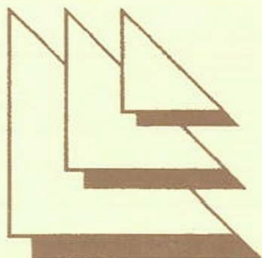

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CHILD'S INFORMATION AND HEALTH HISTORY

Child's name: ______________________ Nickname ____________ Age _____ Birthdate ____________

Child's Address: ______________________________________ Child's Phone: ____________

Hobbies, Sports, Interests: ____

Referred by: ____

I. MEDICAL HISTORY

Child's Physican or Pediatrician ______________ Address ____________ Phone No. ____________

Has your child had a physical exam within the last year? ________ Date ____________

Has your child received emergency medical treatment within the last six months? ____________

Reason ____

Does your child have a heart condition or heart murmur? ________ Explain ____________

Have you ever been told that your Child should have antibiotics before all dental appointments? ________

Has your child ever been hospitalized? ________ Date ________ Reason ____________

____

Has your child ever had a serious illiness or operation? ________ Please list ____________

Has your child had a blood transfusion or received any clotting agents? ____________

Date ________ Reason ____

Does your family or your child have a history of complication from general anesthesia? ________

If so, what type? ____

Has your child received injuries to the head, jaw, mouth or teeth? ________ Describe ____________

Has your child experienced jaw pain or limitation of jaw movement? ____________

Is your child now taking any medications? ________ List/dosage ____________

List all of your child's allergies, include adverse reactions to any drugs or medications. (If none, write "none") ________

____

If your child has or has had any of the following, please circle yes or no on the lines below:

Y N Loss of consciousness	Y N High blood pressure	Y N Asthma	Y N Glandular problems
Y N Autism Spectrum	Y N Kidney disease	Y N Breathing difficulties	Y N Diabetes
Y N Convulsions	Y N Bladder disease	Y N Lung disease	Y N Thyroid disease
Y N Psychiatric treatment	Y N Liver disease (Jaundice)	Y N Pneumonia	Y N Heart Murmur
Y N Seizures	Y N Stomach problems (ulcers)	Y N Nose/Throat disorders	Y N Mitral Valve Prolapse
Y N Epilepsy	Y N Gastrointestinal disorders	Y N Cleft Lip/Palate	Y N Heart condition
Y N Emotional problems	Y N Cancer or Tumors	Y N Recurrent headaches	Y N Rheumatic fever
Y N Alcohol dependency	Y N Chemotherapy/radiotherapy	Y N Eye disorders	Y N Anemia
Y N Chemical dependency	Y N Immunosuppression/deficiency	Y N Ear disorders	Y N Sickle Cell Anemia
Y N Hyperactivity	Y N HIV Antibody/AIDS	Y N Muscle disorders	Y N Blood disease
Y N Attention deficit syndrome	Y N Hepatitis	Y N Arthritis	Y N Hemophilia
Y N Congenital Birth Defects	Y N Skin Disease	Y N Bone disorders	Y N Bleeding tendency
		Y N Endocrine disorders	Y N Bacterial/viral infection

Explain ____

____

____

Does your child have any other medical condition not mentioned above? ____________

Explain ____

____

Does your child have any physical or mental special needs? __________ Explain ______________________

____

Has your child ever had hearing, sight or speech problems? ________ Explain ______________________

____

Is your child currently receiving speech therapy? ________ If yes, by whom? ______________________

____

Has your child ever had learning or behavioral problems? ________ Explain ______________________

____

How would you describe your child's personality/temperment? ______________________

____

II. DENTAL HISTORY

Is this your child's first visit to the dentist? ________
Date of last dental exam ________ Any previous unfavorable dental experience ☐ Yes ☐ No Explain: ________

____

Were X-rays taken? ________ Date of last X-rays? ______________
Has your child had a toothache recently? ______________
Is there a history of oral habits? ________ Please circle: Mouthbreathing / Thumb sucking / Finger sucking / Pacifier sucking / Lip biting or sucking / Nail biting
Is your child currently nursing or taking a bottle? ________
How many bottles per day? ________
Does he/she take the bottle before or to bed? ________
Contents of bottle? ______________________
At what age did your child stop nursing or taking a bottle? ________
Is your child taking any vitamins with fluoride supplements? ________
Does your child use a fluoride rinse? ________
Has your child ever had a dentist applied fluoride treatment? ________
Do you have fluoride in your water system? ________
How often are your child's teeth brushed per day? ________ By whom? ______________
Does he/she snore when sleeping? ________
Is there a history of "night grinding" while sleeping? ________
Chief Complaint/Reason for visit ______________________

____

Is there anything else about your child that you think we should know in order to better treat his/her dental needs?

____

____

____

III. CONSENT

Your child is a minor. Therefore, it is necessary that signed permission be obtained form a parent or guardian before any dental care can begin: I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical / surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the speciality of pediatric dentistry to complete same treatment, including diagnostic radiographs. If my child ever has a change in his / her health or his / her medications change, I will inform the doctor at he next appointment without fail. I will be responsible for the cost of this dental care. At no time will care be rendered to a child without informing parent or guardian of such care along with an estimate of their financial obligation. For specific procedures, further information will always be provided.

Parent's Signature ______________________ Staff ______________ Date ______________

Doctor's Signature ______________________ Date ______________