Child Health History Update

To assist us in serving you, please complete the following confidential health questionnaire update form. The information provided is important to your child's dental health

Your Child

Child's Name: _____

Nickname: _____

DOB: ____/____/_____

Address: _____

City/ State/ Zip _____

Responsible for Scheduling Appointments

Name: _____

Relationship: _____

Soc. Sec #: _____DOB: ___/___/____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Employer: _____

Responsible Party

Same as above { }

Name: _____

Relationship: _____

Soc. Sec #: _____DOB: ___/___/____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Employer: _____

Address (if Different from Child):

_____

City/State/Zip_____

Dental History

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated? Yes { } No { }

Does your child take fluoride supplements? Yes { } No { }

Does your child:

Suck thumb/ finger?	Yes { } No { }
Suck/ bite lip?	Yes { } No { }
Bite/ chew nails?	Yes { } No { }
Chew hard objects? (pencils, etc.)	Yes { } No { }
Clench jaw/ grind teeth?	Yes { } No { }
Complain of tooth pain	Yes { } No { }

Medical History

Child's physician: _____

Phone: _____

Has your child ever had any of the following:

Asthma/ Lung trouble	Yes { } No { }
Cancer	Yes { } No { }
Hepatitis	Yes { } No { }
HIV/ AIDS	Yes { } No { }
Brain Injury	Yes { } No { }
Abnormal bleeding/ Hemophilia	Yes { } No { }
Stomach, liver, kidney trouble	Yes { } No { }
Tuberculosis	Yes { } No { }
Diabetes	Yes { } No { }
Handicaps/ Disabilities	Yes { } No { }
Cerebral Palsy	Yes { } No { }
Rheumatic Fever	Yes { } No { }
Convulsions/ Epilepsy	Yes { } No { }
Heart Condition, please specify	Yes { } No { }

_____

Please list any medical condition(s) that your child has that is monitored by a physician not listed above:

_____

_____

Previous hospitalizations/ surgeries/ serious illness, please list with dates: _____

_____

_____

_____

Is your child currently taking any medications, please list: _____

_____

Does your child have a history of allergies/ sensitivities/ adverse reactions to any medications, anesthetic or any other substance, please list: (Penicillin, Clindamycin, Sulfa, Latex, environmental, etc.) _____

_____

_____

_____

Signature of Parent/ Guardian: Date:

_____ _____

_____ _____

_____ _____