Child Health History

Welcome to our practice!

Today's Date:_____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name_____
Nickname_____ Sex_____
Birthdate_____ Age_____
Soc. Sec. #_____
School_____ Grade_____
Child's Home Address_____
City_____ State_____
Zip_____ Phone_____

Responsible Party

Name_____
Relationship_____
Address_____
City_____ State_____
Zip_____ Phone_____
E-mail _____
Soc. Sec. #_____
Driver's License #_____

Who is responsible for making appointments?

Name_____
Home Phone_____
Work Phone_____ Ext._____

Best time to call_____
Time_____ Days_____

Mother ◯ Stepmother ◯ Guardian

Name_____
Home Phone_____
Work Phone_____ Ext._____
Employer_____
Occupation_____
Soc. Sec. #_____
DL#_____

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Father ◯ Stepfather ◯ Guardian

Name_____
Home Phone_____
Work Phone_____ Ext._____
Employer_____
Occupation_____
Soc. Sec. #_____
DL#_____

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Primary Insurance

Insured's Name_____
Relationship_____
Birthdate_____ Soc. Sec. #_____
Employer_____ Date Employed_____
Occupation_____
Insurance Company_____
Group #_____ Employee #_____
Ins. Co. Address_____
City_____ State_____ Zip_____

Additional Insurance

Insured's Name_____
Relationship_____
Birthdate_____ Soc. Sec. #_____
Employer_____ Date Employed_____
Occupation_____
Insurance Company_____
Group #_____ Employee #_____
Ins. Co. Address_____
City_____ State_____ Zip_____

CONFIDENTIAL

Patient ID #_____

Dental & Health History

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

	Yes	No
How often does your child brush? _____		
How often does your child floss? _____		
Is your child's water fluoridated?	○	○
Does your child take flouride supplements?	○	○

Does your child:

__Suck Thumb/Finger?
__Suck/Bite Lip?
__Bite/Chew Nails?
__Chew Hard Objects (pencils, etc.)
__Clench Jaws?

Previous dentist_____

Address_____

_____

Date of last dental visit?_____

	Yes	No
Has your child had difficulty with previous dental visits?	○	○

Child's physician_____

Address_____

_____

Phone #_____

Has your child ever had any of the following:

__Asthma
__Cancer
__Hepatitis
__HIV/AIDS
__Hemophilia
__Abnormal Bleeding
__Stomach, liver or kidney problems
__Handicaps/Disabilities
__Tuberculosis
__Diabetes
__Rheumatic Fever
__Congenital Heart Defect
__Heart Murmur
__Convulsions/Epilepsy

Please explain any medical problems that your child has:

_____

_____

_____

Previous hospitalizations/ surgeries/serious illness	When?	Yes	No
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		

	Yes	No
Is your child currently taking medications?	○	○

If yes, please list.

_____

	Yes	No
Does your child have a history of allergies/sensitivities/ adverse reactions to any drugs or medications (penicillin, Novocain, etc.)?	○	○

If yes, please describe.

_____

Does your child have a history of allergies to any other substance (latex, environmental, etc.)?

_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of patient or parent if minor	Date
_____	_____
_____	_____
_____	_____