



# CHILD'S MEDICAL HISTORY

## PATIENT INFORMATION

## DENTAL INSURANCE

DATE: \_\_\_\_\_ NAME OF PRIMARY DENTAL INSURANCE: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_ S.S. #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ NAME OF SECONDARY DENTAL INSURANCE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_ S.S. #: \_\_\_\_\_

CHILD'S S.S. #: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SEX:  MALE  FEMALE BIRTH DATE \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

AGE \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

CHILD'S FAVORITE INTEREST, HOBBY? \_\_\_\_\_ FATHER'S EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

\_\_\_\_\_ BUSINESS ADDRESS \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_ MOTHER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

\_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

WHO IS RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT: \_\_\_\_\_ MOTHER'S EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

\_\_\_\_\_ BUSINESS ADDRESS: \_\_\_\_\_

**MEDICAL HISTORY** - Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you, it is necessary to have the following information.

**HAVE YOU EVER OR NOW HAVE** (Please check yes or no):

<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Medicine _____	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional/Eating Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Oral Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problem	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth
<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Gagging	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Bruising Easily	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Growth & Developmental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hearing/Speech Problem	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat (Frequent)
<input type="checkbox"/>	<input type="checkbox"/>	Child Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Adenoid/Tonsil Infection	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Syndrome/Type
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip/Palate	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity			_____
			<input type="checkbox"/>	<input type="checkbox"/>	Jaundice			_____

Child's Pediatrician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of child's last physical and reason \_\_\_\_\_

	YES	NO
Is your child in good health?	<input type="checkbox"/>	<input type="checkbox"/>
Are your child's immunizations up to date?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child being treated for any condition presently?	<input type="checkbox"/>	<input type="checkbox"/>
If so, explain _____		
Is your child taking any medications or drugs? (including vitamins)	<input type="checkbox"/>	<input type="checkbox"/>
If so, explain _____		
Has your child ever been hospitalized/had surgery/received general anesthesia or sedation?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any allergies or reactions to medication?	<input type="checkbox"/>	<input type="checkbox"/>
If so, explain _____		
Does your child have any allergies to the following:		
<input type="checkbox"/> Pollen <input type="checkbox"/> Food <input type="checkbox"/> Food Dyes <input type="checkbox"/> Dust <input type="checkbox"/> Other		
Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware that has not been covered _____		

### DENTAL INFORMATION

Is this an emergency visit?       YES       NO      If no, reason for visit \_\_\_\_\_

Is this your child's first dental visit?       YES       NO

If no, name of former dentists? \_\_\_\_\_ Date of last visit \_\_\_\_\_ Purpose \_\_\_\_\_

Present dental problem as you see it (if any) \_\_\_\_\_

	Y	N	
Was your child bottle fed?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, until what age? _____
Was your child breast fed?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, until what age? _____
Has your child had any injuries to his teeth, mouth, head or jaw?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, describe _____
Does your child brush daily?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when _____
Does an adult assist with brushing?	<input type="checkbox"/>	<input type="checkbox"/>	
What brand of toothpaste does your child use?			_____
Has your child ever had x-rays taken?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, by which Doctor? _____
Has your child had local anesthesia (Novocaine)?	<input type="checkbox"/>	<input type="checkbox"/>	Any complications? _____
Has your child ever had sweet air (nitrous oxide)?	<input type="checkbox"/>	<input type="checkbox"/>	Any complications? _____
Does / did your child had any of the following habits?			<input type="checkbox"/> Use of nursing bottle <input type="checkbox"/> nail biting
<input type="checkbox"/> finger sucking <input type="checkbox"/> thumb sucking <input type="checkbox"/> pacifier <input type="checkbox"/> tongue thrusting <input type="checkbox"/> mouth breathing <input type="checkbox"/> tooth grinding			

Does your child receive fluoride in any of the following forms:

In vitamin tablets/drops vitamin name \_\_\_\_\_ Dosage \_\_\_\_\_mg/day       In water supply       In toothpaste       In rinse/gargle

Please check any of the following that may describe your child:

<input type="checkbox"/> Outgoing	<input type="checkbox"/> Shy	<input type="checkbox"/> Stubborn	<input type="checkbox"/> Anxious	<input type="checkbox"/> Frightened	<input type="checkbox"/> Defiant
<input type="checkbox"/> Suspicious	<input type="checkbox"/> Moody	<input type="checkbox"/> High Strung	<input type="checkbox"/> Regular Kid	<input type="checkbox"/> Friendly	<input type="checkbox"/> Cooperative

How has your child reacted to previous dental visits?       Positive       Negative      If negative, explain \_\_\_\_\_

How do you expect your child to react to his visit today? \_\_\_\_\_

Excellent       Good       Fair       Poor       Don't Know

### AUTHORIZATION AND FINANCIAL RESPONSIBILITY

Because your child is a minor, it becomes necessary that signed permission be obtained from a parent or guardian before any/all necessary services can be performed. I acknowledge that the information above and on the other side is correct. I authorize the doctor to take x-rays, photographs or other diagnostic aids deemed appropriate to make a thorough diagnosis and grant this office permission to provide my child's dental treatment. This consent is also valid for emergency treatment, if necessary, even in my absence. Furthermore, I understand that if my insurance does not cover the cost of this dental care, I will become financially responsible for it.

\_\_\_\_\_  
(Signature of parent or guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to child)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Doctor's Signature)