CHILD 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.

Child's Name_____Date of Birth_____
How often does your child brush?_____How often does your child floss?_____
Previous Dentist_____Date of last dental visit_____
Has your child had difficulty with previous dental visits?_____

	YES	NO
Is your child's water fluoridated?	☐	☐
Does your child take fluoride supplements?	☐	☐
Does your child:		
Suck thumb/finger?.	☐	☐
Suck/Bite lip?	☐	☐
Bite/Chew nails?	☐	☐
Chew hard objects (pencils,etc.)?	☐	☐
Grind teeth?	☐	☐
Clench jaws?	☐	☐

Child's Physician_____Phone # _____
Address_____
Previous hospitalizations / Surgeries / Serious Illnesses, and When?

_____

_____

Is your child currently taking medications? YES ☐ NO ☐ If yes, please list._____

_____

Has your child ever taken Fen-Phen/Redux? YES ☐ NO ☐
Does your child have a history of allergies, sensitivities, adverse reactions to any drugs or medications (penicillin, Novocain, etc.? YES ☐ NO ☐ If yes, please explain._____
Does your child have a history of allergies to any other substance (latex, environmental, etc.)?_____

_____

Has your child ever had any of the following:

Asthma	☐ Yes ☐ No	Stomach, liver or kidney problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Handicaps/Disabilities	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No
A persistent cough or throat clearing not associated with a known illness and lasting more than 3 weeks	☐ Yes ☐ No	Abnormal Bleeding	☐ Yes ☐ No
		Convulsions/ Epilepsy	☐ Yes ☐ No

Please explain any medical problems that your child has:_____

_____

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.*

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or Examinations rendered to my child during the period of such care to third party payers and or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date