



CHILD HISTORY FORM

DATE _____

Child's Name _____ Sex: M F Age _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Phone _____

Father's Name _____ Work Phone: _____ Cell: _____

Mother's Name _____ Work Phone: _____ Cell: _____

Parents E-mail address: _____

DENTAL INSURANCE

Name of Insurance: _____ Insurance phone: _____

Subscriber's Name: _____ Relationship to patient: _____

Subscriber's Employer: _____ Work Phone: _____

Subscriber's date of birth: _____ Subscriber's SS#: _____

Parent's Marital Status (X): Married _____ Single _____ Widowed _____ Separated _____ Divorced _____

How did you hear about our office: Location Word of mouth Yellow pages Mailer Other _____

List Names and Ages of Brothers and Sisters:

Child's School _____ Grade _____

What is your child's favorite: School Subject _____

Pet _____ TV Shows _____

Sport _____ Hobbies _____ Person _____ - _____

DENTAL HISTORY

Date of last visit to a dentist _____ Any unusual speech habits? Yes No

For what service? _____ Orthodontic appliances worn now or ever been? Yes No

Name of previous dentist _____ Does your child brush teeth daily? Yes No

May we request previous records? Yes No Do you assist child with tooth brushing? Yes No

Has child complained about dental problems? Yes No Is dental floss used? Yes No

Any unhappy dental experiences? Yes No Is fluoride taken in any form? How? _____ Yes No

_____ Child's attitude to dentistry _____

Any injuries to mouth, teeth or head? Yes No Do you anticipate your child having difficulty accepting dental treatment? Yes No

Any mouth habits - thumbsucking, finger sucking, mouth breathing, nursing bottle habits, pacifier (Circle) Yes No Do you desire complete dental service for the child? Yes No

_____ Are there any dental problems bothering your child at this time? Yes No

(Over Please)

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

Is child under care of physician now? Yes No Has child ever been hospitalized? Yes No

Why? _____ Why? _____

Is child receiving any medication or drugs? Yes No Does child have good physical coordination? Yes No

What? _____ _____

Is there any excessive bleeding when cut? Yes No Are there any emotional or nervous problems? Yes No

_____ Explain: _____

• IS YOUR CHILD ALLERGIC TO:

PENICILLIN _____ ANTIBIOTICS _____ LOCAL ANESTHETIC (NOVOCAINE) _____

ASPIRIN _____ FOODS _____ LATEX _____ OTHER _____

• DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS THAT YOU WOULD LIKE TO TALK ABOUT PRIVATELY

WITH THE DENTIST? YES NO _____

• Does your child have or ever had any of the following? (Please place X and explain below):

_____ Anemia	_____ Cleft Lip or Palate	_____ Heart Problems	_____ Rheumatic Fever
_____ Asthma	_____ Convulsions	_____ Jaundice	_____ Sight Problems
_____ Bladder Problems	_____ Diabetes	_____ Kidney Problems	_____ Speech Problems
_____ Blood Disorders	_____ Epilepsy	_____ Liver Problems	_____ Thyroid Problems
_____ Cerebral Palsy	_____ Fainting	_____ Mental Retardation	_____ Tuberculosis
_____ Chronic Sinus	_____ Hearing Problems	_____ Murmurs	_____ Other

EXPLAIN: _____

ADDITIONAL COMMENTS: _____

Since this patient is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any dental service can be performed. Authorization is hereby granted as such. PAYMENT IS DUE WHEN SERVICES ARE RENDERED. Unless 24 hour notice is given, there will be a charge for a broken appointment.

Signature _____

Relationship to Child _____

Thank you for giving us the privilege of seeing your child. We are anxious to provide the best possible care. The answers to these questions will help make this possible. Thank You For Your Cooperation!