Child History Form

Today's Date _____

Child's Name _____
Last First Initial

Nickname _____ Soc. Sec. #_____

Address _____

Male___ Female ___ Age ___ Birthdate ___/___/___ School _____

Grade _____ Hobbies/Sports _____

Toy_____ Favorite Person_____ Fictional Character_____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name _____ Relation _____

Do you have legal custody of this child? Yes___ No___

Is the child adopted? Yes___ No___

Is the child in a foster home? Yes___ No___

Why did you bring the child to the dentist today? _____

What is the child's attitude toward dentistry? _____

Has the child ever had a serious/difficult problem associated with previous dental work? Yes____ No ____

Any injuries to mouth? Yes____ No ____

Is the child's water fluoridated? Yes____ No ____

Is the child taking fluoridated supplements? Yes____ No ____

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes____ No ____

Any orthodontic appliances worn now or in the past? Yes____ No ____

Does the child brush his/her teeth daily? Yes____ No ____

Floss his/her teeth daily? Yes____ No ____

Child's Physician _____ Phone _____

Date of last visit_____

Is the child currently under the care of a physician? Yes ____ No____

Please describe the child's current physical health: Good ____ Fair ____

Please list all drugs that the child is currently taking: _____

_____

Please list all drugs that the child is allergic to: _____

_____

Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Convulsions/Epilepsy	Y	N	HIV+/AIDS
Y	N	Allergies to any Drugs	Y	N	Diabetes	Y	N	Immunizations Current
Y	N	Anemia	Y	N	Exposed to HIV but neg	Y	N	Kidney/Liver Problems
Y	N	Any Hospital Stays	Y	N	Handicaps/Disabilities	Y	N	Measles
Y	N	Any Operations	Y	N	Hearing Impairment	Y	N	Mononucleosis
Y	N	Asthma	Y	N	Heart Murmur	Y	N	Rheumatic/Scarlet Fever
Y	N	Cancer	Y	N	Hemophilia	Y	N	Skin Rash
Y	N	Chicken Pox	Y	N	Hepatitis	Y	N	Tuberculosis (TB)
Y	N	Congenital Heart Defect	Y	N	Hives			

Does/did the child have any of the following habits?

Y	N	Lip Sucking/Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb/Finger Sucking

Whom may we thank for referring you? _____
Other siblings seen by us? _____
Previous Dentist _____
Last Visit Date _____

PARENT'S INFORMATION

___Mother ___Stepmother ___Guardian

Name_____ Birthdate ___/___/___
Address_____ Home Phone_____
_____ Work Phone _____ Ext _____
Employer _____ SS# _____

___Father ___Stepfather ___Guardian

Name_____ Birthdate ___/___/___
Address_____ Home Phone_____
_____ Work Phone _____Ext._____
Employer _____ SS# _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____
Billing Address _____ Home Phone _____
_____ Work Phone _____
Employer _____

Who is responsible for making appointments? _____
Home Phone _____ Work Phone _____Ext._____

PRIMARY DENTAL INSURANCE

Insur. Co. Name _____ Phone _____
Address_____
Subscriber's Name _____ DOB ___/___/___
Soc. Sec. # _____ Group/Policy # _____
Employer_____Address_____

SECONDARY DENTAL INSURANCE

Insur. Co. Name_____ Phone _____
Address _____
Subscriber's Name _____ DOB ___/___/___
Soc. Sec. # _____ Group/Policy #_____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date