Pediatric Dentistry Health Information

DATE _____

CHILD'S NAME	NICKNAME	AGE	BIRTHDATE

SCHOOL	GRADE	RESIDENCE ADDRESS	ZIP

FATHER'S NAME	MOTHER'S NAME	PARENT'S TELEPHONE NUMBER (H) (W)

BROTHERS	SISTERS

IF APPLICABLE, DENTAL INSURANCE CARRIER	SOCIAL SECURITY NO.

CHILD'S FAVORITE HOBBY	CHILD'S FAVORITE SPORT	ANY PETS?

DENTAL HISTORY

	YES	NO
DATE OF LAST DENTAL VISIT _____		
FOR WHAT _____		
_____ BY DR. _____		
ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS? _____	☐	☐
HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS? _____	☐	☐
ANY INJURIES TO MOUTH, TEETH, HEAD? _____	☐	☐
ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING, MOUTHBREATHING, ETC.? _____	☐	☐
ANY LOST TEETH? _____	☐	☐

	YES	NO
DOES YOUR CHILD BRUSH DAILY? _____	☐	☐
DO YOU ASSIST YOUR CHILD WITH BRUSHING?		
HOW OFTEN _____	☐	☐
IS DENTAL FLOSS USED? _____	☐	☐
ARE DISCLOSING TABLETS USED? _____	☐	☐

HOW DOES YOUR CHILD RECEIVE FLUORIDE?

☐ WATER SUPPLY ☐ TOOTHPASTE

☐ DENTIST ☐ VITAMIN ☐ TABLETS

☐ NONE ☐ OTHER _____

CHILD'S ATTITUDE TO DENTISTRY _____

_____

_____

MEDICAL HISTORY

CHILD'S PHYSICIAN _____ ADDRESS _____ PHONE _____

DATE OF LAST COMPLETE PHYSICAL EXAMINATION? _____ RESULTS _____

	YES	NO
IS YOUR CHILD IN GOOD HEALTH? _____	☐	☐
IS YOUR CHILD PRESENTLY UNDER CARE BY A PHYSICIAN? _____	☐	☐
IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS? _____	☐	☐
WHAT IS YOUR CHILD'S WEIGHT _____ HEIGHT _____		
HAS YOUR CHILD EVER BEEN HOSPITALIZED? _____	☐	☐
_____		
HAS YOUR CHILD EVER HAD SURGERY? _____	☐	☐

EATING HABITS PRESENTLY - BRIEFLY EXPLAIN _____

ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION? YES ☐ NO ☐

_____

_____

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

	YES	NO
1. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE	☐	☐
2. CONGENITAL HEART DISEASE OR HEART MURMUR	☐	☐
3. ALLERGIES: A) FOOD, DUST, ETC.	☐	☐
B) DRUG, i.e. Penicillin, etc.	☐	☐
C) UNKNOWN	☐	☐
4. ASTHMA OR HAY FEVER	☐	☐
5. ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS)	☐	☐
6. DIABETES OR BLOOD SUGAR PROBLEMS	☐	☐
7. ANY PROLONGED BLEEDING OR BRUISES EASILY	☐	☐
8. KIDNEY OR BLADDER PROBLEMS	☐	☐
9. ANEMIA OR BLOOD DISORDERS	☐	☐
10. TUBERCULOSIS OR PNEUMONIA	☐	☐
11. LIVER PROBLEMS, JAUNDICE OR HEPATITIS	☐	☐
12. GLANDULAR OR HORMONAL PROBLEMS	☐	☐
13. ACCIDENTS OR SEVERE INFECTIONS	☐	☐
14. CONVULSION, SEIZURES, FAINTING OR EPILEPSY	☐	☐
15. HIGH/LOW BLOOD PRESSURE	☐	☐
16. SPEECH, LEARNING, OR HEARING DISORDERS	☐	☐
17. CHILDHOOD ILLNESSES	☐	☐
18. IMMUNIZATIONS	☐	☐
19. Has your child ever had any orthopedic total replacement	☐	☐
Date _____ What _____ Any complications _____		
20. OTHER, IF SO EXPLAIN	☐	☐

IF YES, PLEASE EXPLAIN _____

SUMMARY: (FOR DOCTOR'S USE)

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION DENTIST SHOULD BE AWARE OF THAT HAS NOT BEEN COVERED ABOVE.

_____

_____

HISTORY TAKEN FROM

_____ RECORDED BY _____ DATE _____

SUBSEQUENT HISTORIES BY: RELATIONSHIP

_____ RECORDED BY _____ DATE _____

NAME RELATIONSHIP

_____ RECORDED BY _____ DATE _____

NAME RELATIONSHIP

_____ RECORDED BY _____ DATE _____

NAME RELATIONSHIP

_____ RECORDED BY _____ DATE _____

NAME RELATIONSHIP

I hereby certify the foregoing information is correct and true. Because _____ is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Authorization is hereby granted as such. Furthermore, I will be responsible for any professional fees occured for dental services to my child. I hereby authorize payment directly to below-named dentist of the group insurance benefits otherwise payable to me.

Parent or Guardian Signature _____ Date _____

Dr. Signature _____ Date _____