

Children's Health/Dental History Form

Child's Name: _____
Last First MI

Nickname: _____ M or F (circle) Birth date: ____/____/____ Age: _____

Social Security #: ____-____-____ Home Phone # (____) ____-____

Child's Home Address: _____

City State Zip

Person Responsible for Account: _____ Relationship: _____

Mother/Stepmother/Guardian (please circle):

Name: _____ Date of Birth ____/____/____

E-Mail: _____ Social Security # ____/____/____

Home Phone # (____) ____-____ Work Phone # (____) ____-____ Ext ____

Employer: _____ Occupation: _____

Father/Stepfather/Guardian (please circle): Name: _____

Date of Birth ____/____/____

E-Mail: _____ Social Security # ____/____/____

Home Phone # (____) ____-____ Work Phone # (____) ____-____ Ext ____

Employer: _____ Occupation: _____

Primary Dental Insurance:

(In order for us to help provide you with accurate Dental Benefit Information please allow us to copy your card)

Insured's Name: _____ Relationship: _____

Date of Birth: ____/____/____ Social Security # ____/____/____

Insurance Company: _____ Group No. _____

Member ID _____ Employer: _____

Secondary Dental Insurance:

(In order for us to help provide you with accurate Dental Benefit Information please allow us to copy your card)

Insured's Name: _____ Relationship: _____

Date of Birth: ____/____/____ Social Security # ____/____/____

Insurance Company: _____ Group No. _____

Member ID _____ Employer: _____

Children's Health/Dental History Form

Your child's overall health as well as any medications that your child may take could play an important role in your child's dental treatment. Please answer each of the following questions completely.

Has the child had any history of, or condition related to, any of the following:
(Please circle a Y or N answer for each condition)

Anemia	Y N	Epilepsy	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Fainting	Y N	Seizures	Y N
Asthma	Y N	Hearing	Y N	Sickle Cell	Y N
Blood Disorders	Y N	Heart	Y N	Thyroid	Y N
Bones/Joints	Y N	Hepatitis	Y N	Tuberculosis	Y N
Cancer	Y N	HIV/AIDS	Y N	Other	Y N
Cerebral Palsy	Y N	Kidney	Y N		
Chicken Pox	Y N	Latex Allergy	Y N		
Chronic Sinusitis	Y N	Liver	Y N	Allergic to: Penicillin, Sulfa, Codeine	
Diabetes	Y N	Measles	Y N	Acetometaphine, Ibuprophen	
Ear Aches	Y N	Mumps	Y N	Other: _____	

If you answered Yes to any of the above please provide us with any additional information:

Is the child taking any prescription medications or over the counter medications? Y
N

If Yes, please list _____

Has the child ever had a serious illness? If yes, please explain? _____
Y N

Has the child ever been hospitalized?
..... Y N

Is the child physically, mentally or emotionally impaired?
Y N

Is the child currently being treated for any illness? Y
N

Is this the child's first visit to the dentist? If not, when was the last visit? _____
Y N

Has the child had any problem with dental treatment in the past?
Y N

Has the child ever had x-rays taken before? Y
N

Has the child ever suffered any injury to the head, neck or teeth? Y
N

Has the child had any problems with the eruption or shedding of teeth? Y
N

Has the child had orthodontic treatment? Y
N

Does the child suck his/her thumb, fingers or pacifier? Y
N

What type of water does your child drink? (circle) **City Water/Well Water/Bottled Water/Filtered Water**

Does the child take fluoride supplements? Y N

Is Fluoride toothpaste used? Y N

Is a fluoride rinse

used?

..... Y N

How many times per day are the child's teeth brushed? _____ When are they brushed?

How often are the child's teeth flossed?

Does the child participate in recreational activities? What? _____ Y
N

I certify that I have read and understand the above. I attest under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct. Any omissions that I have made in the completion of this form, I am responsible for.

Parent's/Guardian's Signature: _____ Date:

Dr's Signature: _____ Date:
