CHILD'S HEALTH HISTORY

Date of Last Dental Visit _____

What did you see the Dentist for? _____

What Dentist do you see? _____

	Yes	No
Any previous unhappy medical or dental visits?	☐	☐
Has your child complained of any dental problems?	☐	☐
Any injuries of the mouth, teeth, or head?	☐	☐
Any mouth habits: Nail biting, thumb-sucking etc.…?	☐	☐
Has your child lost any teeth since his/her last dental visit?	☐	☐
Does your child brush his/her teeth daily?	☐	☐
Do you help assist your child with brushing his/her teeth?	☐	☐
If yes, how often do you help your child?	☐	☐
Does he/she use Dental Floss?	☐	☐
How does your child receive Fluoride?	☐	☐

Water supply ☐ Toothpaste ☐ Dentist ☐ Vitamins ☐ Tablets ☐ None ☐

How is your child's attitude towards dentistry? _____

MEDICAL HISTORY

Child's Primary Physician _____

Physician's Address (street, City, State, Zip) Phone Number

_____

Date of last Examinations _____

Result's of last examination _____

	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?	☐	☐

If yes, what? _____

What is your child's weight? _____ lbs. Height _____

Has your child ever been hospitalized?	☐	☐

If yes, when? _____

Eating Habits presently (briefly explain) _____

_____

Are there any psychological or emotional problems?	☐	☐

if yes, please explain _____

_____

Have they has any of the following problems?

1. Rheumatic Fever/ Heart Disease	☐	☐
2. Congenial Heart Disease or Heart Murmur	☐	☐
3. Allergies	☐	☐

If yes, what? _____

Food, Dust, etc. _____

Drugs i.e. Penicillin etc. _____

	YES	NO
4. Asthma or Hay Fever	☐	☐
5. Diabetes or blood sugar problems	☐	☐
6. Any prolonged bleeding or bruises easily	☐	☐
7. Swollen joints	☐	☐
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 infection	☐	☐
14. Convulsions, Seizures, Fainting or Epilepsy	☐	☐
15. High/Low Blood Pressure	☐	☐
16. Speech, Learning, or Hearing Problems	☐	☐
17. Childhood Illness	☐	☐
18. Immunizations	☐	☐

Any Other, Please explain

_____

_____

Summary (Doctor's Use Only)

Please describe any current medical treatment including drugs, pending surgeries, recent injuries or any other information the Dentist should be aware of not covered above

_____

_____

History Taken From _____

Recorded By _____ Date _____

Subsequent histories by (Relationship) _____

Name (Relationship) _____ Recorded By _____

Date _____ _____

Name (Relationship) _____ Recorded By _____

Date _____

I HEREBY CERTIFY THE FOREGOING INFORMATION CORRECT AND TRUE. BECAUSE _____ IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A GUARDIAN OR PARENT 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 INCURRED FOR DENTAL SERVICE TO MY CHILD. I AUTHORIZE ANY PARTICIPATING DENTAL OFFICE TO RELEASE MY CHILD'S DENTAL RECORDS FOR ADMINISTRATION PURPOSES.

SIGNED _____ **DATE** _____