Medical/Dental History For Children

The parent or Guardian who accompanies the child is responsible for payment at the time of service.

Tell Us About Your Child

Child's name

Nickname

Birth Date

Gender
Male Female

Siblings that we treat:

Home Address City Zip

Child's School

Whom may we thank for referring you to our office?

Who is Accompanying the Child Today?

Name Relationship

Do you have legal custody of this child? Yes No

Mother's Information

Mother's name

Mother's birth date

Mother Stepmother Guardian

Mother's employer

Phone (work) Phone (home) Phone (mobile)

Father's Information

Father's name

Father's birth date

Father Stepfather Guardian

Father's employer

Phone (work) Phone (home) Phone (mobile)

Child's Physician

Physician's name Phone (work)

Is the child currently under the care of a physician for a specific health issue?
Yes No

Please describe the child's current physical health...
Good Fair Poor

Primary Dental Insurance

Insurance Co. Name Phone

Group Member

Policy Holder's Name Relationship to Patient

Policy Holder's Birthdate Social Security

Secondary Dental Insurance (IF ANY)

Insurance Co. Name Phone

Group Member

Policy Holder's Name Relationship to Patient

Policy Holder's Birthdate Social Security

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Policy Holder's Employer

Policy Holder's Employer

Dental History

Is this your child's first visit to the dentist?	Yes	No
If not, how long since the last visit to the dentist?		
Any x-rays taken at previous dental visits?	Yes	No
Have there been any injuries to the teeth, face or mouth?	Yes	No
If yes, please explain		

Why did you bring the child to the dentist today?

Does the child have any of the following habits?

Lip Sucking / Biting	Yes	No
Nail Biting	Yes	No
Nursing / Bottle Habits	Yes	No
Thumb / Finger Sucking	Yes	No
Has the child ever had a serious or diffcult problem associated with previous dentalwork?	Yes	No
If yes, please explain		
Is the child currently in pain?	Yes	No
Has the child ever had any pain or tenderness inhis/her jaw/joint? (TMJ/TMD)?	Yes	No
Does the child brush his/her teeth daily?	Yes	No
Floss his / her teeth daily?	Yes	No

What is your child's temperment?

Friendly Shy Nervous Scared Willed

Does the child currently have or has the child ever had any of the following conditions?

Floss his / her teeth daily?	Yes	No
Abnormal Bleeding	Yes	No
Allergies to any Drugs	Yes	No
Any Hospital Stays	Yes	No
Any Operations	Yes	No
Autism Spectrum Disorder	Yes	No
Asthma	Yes	No
ADHD/ADD	Yes	No
Hay Fever/Seasonal Allergies	Yes	No
Emotional Problems	Yes	No
Sensory Disorder	Yes	No
Speech Delays	Yes	No
Cancer	Yes	No
Cerebral Palsy	Yes	No
Congenital Birth Defects	Yes	No
Convulsions/Epilepsy	Yes	No
Developmental Delays	Yes	No
Diabetes	Yes	No
Down's Syndrome	Yes	No
Pregnancy	Yes	No
Handicaps/Disabilities	Yes	No
Hearing Impairment	Yes	No
Heart Disease/Murmur	Yes	No
Hemophilia/Blood Disorders	Yes	No
Sickle Cell Anemia/Trait	Yes	No
Hepatitis	Yes	No
HIV+/AIDS	Yes	No
Kidney/Liver Conditions	Yes	No
Rheumatic/Scarlet Fever	Yes	No
Allergies to Latex Product	Yes	No
Tuberculosis	Yes	No

Please discuss any serious medical conditions the child has/had:

Please list all drugs the child is currently taking:

Please list all drugs the child is allergic to:

Please list any other allergies:

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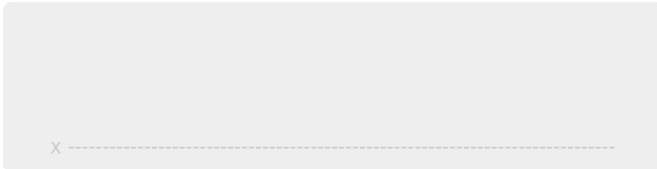
I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
I authorize the dental staff to perform the necessary dental services my child may need.
I have reviewed the medical / dental information above with the parent / guardian and patient named herein.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

First & Last Name

Email Address

Signature



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