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CHILD MEDICAL HEALTH HISTORY – 15 years old and younger

Although dental professionals primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name (Last, First)_____ DOB:_____ Date:_____
Pediatrician Name_____Date of last physical exam_____
Pediatrician address/phone number_____

Is your child under the care of a physician or other medical professional? If yes, for what reason? No □ Yes □_____
_____
Does your child have a condition or disability that prevents/complicates treatment in a dental office? No □ Yes □_____
_____

Has your child been hospitalized? Provide dates and reason. No □ Yes □_____
Has your child ever had a serious Accident, Illness, Operation? No □ Yes □_____
Does your child have allergies (medications, foods, metals, etc.)? No □ Yes □_____
Is your child taking any medications (including non-prescription)? No □ Yes □_____
Was your child born prematurely? How many weeks? No □ Yes □_____

Does your child have a history or presently have any of the following:

□ Abnormal bleeding	□ Cardiovascular Disease	□ Hay Fever	□ Mononucleosis
□ Anaphylaxis	□ Cerebral Palsy	□ Hearing Disability	□ Persistent Cough
□ Anemia	□ Chronic Sinus	□ Hemophilia	□ Speech Impairment
□ Arthritis	□ Cleft lip or palate	□ Hepatitis	□ Stomach Ulcers
□ Asthma/Respiratory issues	□ Congenital Heart Disorder	□ Hives or Rash	□ Thyroid Disease
□ Autoimmune/Immunosuppressed	□ Diabetes	□ Jaundice	□ Tonsillitis
□ Blood Disorder	□ Emphysema	□ Kidney Problems	□ Tuberculosis
□ Bruise easily	□ Epilepsy or Seizures	□ Liver Disease	
□ Cancer	□ Fainting Spells/Dizziness	□ Mental Health Issues	

Is there any other information we should be aware of that we have not discussed?_____
_____
_____

May we request release of child's medical records for our reference?_____

This information was discussed with and given by_____ Relation to child_____

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CHILD DENTAL HEALTH HISTORY

Patient Name (Last, First)_____ DOB:_____ Date:_____
Date of last dental visit?_____ Last dental cleaning?_____ Last X-Rays?_____
Name of previous dentist_____
Address_____City_____State_____Zip_____

Describe your child's experience at his/her last dental visit and/or how you anticipate he/she will respond to treatment_____
_____
Has your child had orthodontic treatment?_____
Has your child experienced any traumatic incident involving face, teeth or gums?_____

Preventative History

Do you have fluoride in your water?_____ Does your child take fluoride supplements? _____
How often does your child brush his/her teeth? _____How often does your child floss his/her teeth? _____
Can child reliably spit out toothpaste? No □ Yes□ Type of toothpaste_____

Diet/Behavioral

Does your child breast feed/use bottle at night? (now or in the past)_____x/day
Does your child use a sippy cup or bottle during the day? (now or in the past)-frequency_____
Does your child suck on fingers or other objects/pacifier? (now or in the past)- frequency_____
Does your child drink juice or soda? □ No □ Yes If so, how much per day and what type?_____
Does your child eat Candy □/Other Sweets□/Chew Gum □? If so, what types and how often?_____
Does your child eat simple Carbohydrates (pasta, bread, sugared-cereal, crackers, cookies) during the day? No □ Yes □
Types and frequency of consumption_____

Oral History

Please enter child's age at date of first tooth eruption_____
Does your child have any of the following?
Tooth Pain □ Sensitivity to Sounds □ Strong gag reflex □ Fear of needles or other problems with injections □
Experience problems with tastes or flavors, especially toothpaste? No □ Yes □
Specific fears or sensitivities which may impact on his/her dental care? No □ Yes □ If yes, briefly describe_____
_____
Have other habits you would like evaluated or feel we should know about? No □ Yes □_____
_____

Parental/Family Dental History

Does your child's care giver fear visiting the dentist? No □ Yes □. If yes, please describe_____
Do any of the child's parents/caregivers have a large number of cavities or other significant dental problems? No □ Yes □
If yes, please describe_____
Does either parent require orthodontic treatment (now or in the past)? No □ Yes □_____

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Has either parent experienced any dental conditions such as enamel problems, missing teeth, extra teeth, need for jaw surgery, other? No □ Yes □ If yes, please describe_____

Has either parent been diagnosed as having periodontal disease? No □ Yes □

Are there any other concerns or issues you would like to discuss with us? No □ Yes □ If yes, please describe_____

_____

_____

_____

Who may we contact in case of an emergency? Name _____

Relationship_____ Phone #_____

For completion by dentist

Comments_____

_____

_____

_____

_____

_____

_____

_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes, I agree to notify the office and treating dental professional.

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor may choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% per month finance charge may be added to my account, in addition to any collection charges.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Please print name Relationship to patient