Children's Health History Form

Child's Name: ____ Nickname: _______________________________ Gender: M F

Birth date: _____________ Home Phone: ________________________ e-mail: ____

Child's Home Address: _______________________________________ City: ______________________ State: _______ Zip: ________

School: ____ Grade: _________________________

Child's Primary Physician: ______________________________________ Phone: ____

Other Treating Specialist: _______________________________________ Phone: ____

Parent's Information

Parent's Marital Status: Married Separated Divorced Remarried Widowed Single

Mother's Information

Name: ___________________________________ Spouses Name (if different than father):___________________________________

Address (if different than child's):________________________________ City______________________ State_______ Zip___________

Home Phone: ______________________________ Cell Phone: _________________________ Work Phone: ______________________

Father's Information

Name: ___________________________________ Spouses Name (if different than mother):__________________________________

Address (if different than child's):________________________________ City______________________ State_______ Zip___________

Home Phone: ______________________________ Cell Phone: _________________________ Work Phone: ______________________

Medical History

Y N Does your child have any health problems? (No matter how insignificant):
(If yes, please explain):____

Y N Has your child ever been in the hospital or had surgery?

Y N Does your child have any allergies to food or medication?
(If yes, please explain):____

Y N Does your child have, or has he/she ever had the following? (check all that apply)

❑ Heart Disorder ❑ Seasonal Allergies ❑ Asthma ❑ Diabetes ❑ Gastric Reflux ❑ Hepatitis
❑ Seizure Disorder ❑ Kidney Disorder ❑ Cancer ❑ HIV/TB ❑ Liver Disorder ❑ Blood Disorder
❑ Contagious Disease ❑ Chronic Condition ❑ Other, explain ____
❑ **None of the above**

Y N Is your child taking any medications? (If yes, please list and give reason): ____
____

Y N Has your child ever had an unfavorable reaction to drugs, including antibiotics?
(If Yes, which):____

Y N Does your child have an emotional/behavioral or learning disorder? (If yes, please describe):
____

(continued on back)

Dental History

Y N Does your child have a habit of thumb or finger sucking, lip or nail biting, or pacifier?
(If yes, please circle condition) History of habit? Y N Stopped when? ____________________________________

Y N Has your child had a toothache recently?

Y N Has either parent had a lot of tooth decay?

Y N Are you satisfied with the appearance of your child's teeth?

Y N Does your child play sports? If yes, do they wear an athletic guard? Y N

Y N Has your child seen an orthodontist? If yes, who? ____

Y N Has anyone in your family had orthodontic treatment? If yes, who? ____

Y N Does your child have any speech issues?
If yes, please explain____

Current Oral Health Habits

Does your child receive fluoride in any of the following forms? (check all that apply)

❑ Toothpaste ❑ Water ❑ Tablets ❑ Vitamin drops ❑ Rinses ❑ Other____________________

Brushing:

Toothbrush: ❑ Soft ❑Medium ❑Hard ❑Electric Frequency per day:___________________

Y N Do you assist your child? If yes, how often? _____________________

Y N Does your child floss? If yes, how often? _______________________

Please list the snack foods that your child eats ____

Form completed by ___________________________________ Signature____________________________________ Date___________

Dentist's Signature____ Date___________

Consent for Treatment

Our office policy is to administer fluoride treatments to children 19 years and under ***every 6 months*** and to take bitewing x-rays on all patients ***every 12 months.*** Consent is required for these procedures to be completed. In the case of a minor, parental/guardian consent is required.

In the event that you may not be present when your child is seen, we would like to have your written consent for these procedures. As it is not always easy to locate a parent or guardian that is not present, this form is a way we can simplify things; it would allow us to administer fluoride and take bitewing x-rays as outlined above, even if the parent/guardian is not with the patient. ***As always, if there is any other work or x-rays required that are not of the above nature, you will be advised prior to treatment.***

I hereby certify that I am this child's parent or legal guardian. I further certify that I understand and agree to the above statements.

____

(Signature Parent/Guardian) (Date)