Child Health/Dental History Form

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COSMETIC AND FAMILY DENTISTRY

E-mail: Today's Date:

Reset Form

Name: Last First Initial	Nickname:	Date of Birth:
Parent's/Guardian's Name:	Relationship to Patient	
Address: Mailing address	City:	State: Zip:
Phone: Home Work		Sex: M ☐ F ☐
Insurance Co. Name*:		Insurance Co. Phone: Include area code ( )
Insurance Co. Address: Mailing address	City:	State: Zip:
Group # (Plan, Local or Policy):	Primary insured's employer:	
Primary Insured's Name:	Relationship to Primary Insured:	
Primary Insured's DOB:	Primary Insured's SS#:	
Primary Insured's address: Mailing address	City:	State: Zip:
Whom may we thank for referring you?	Please list other family members seen by us:	

Have you had active Tuberculosis, persistent cough greater than a three week duration, or a cough that produces blood? ..... **Yes** ☐ **No** ☐

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

If you are completing this form for another person, what is your relationship to that person?

Your Name

Relationship

**If you have your insurance card on hand provide to receptionist and you may need not complete the insurance related questions*

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cerebral Palsy	☐ Growth Problems	☐ Latex allergy	☐ Seizures
☐ Arthritis	☐ Chicken Pox	☐ Hearing	☐ Liver	☐ Sickle cell
☐ Asthma	☐ Chronic Sinusitis	☐ Heart	☐ Measles	☐ Thyroid
☐ Bladder	☐ Diabetes	☐ Hepatitis	☐ Mononucleosis	☐ Tobacco/Drug Use
☐ Bleeding disorders	☐ Ear Aches	☐ HIV +/AIDS	☐ Mumps	☐ Tuberculosis
☐ Bones/Joints	☐ Epilepsy	☐ Immunizations	☐ Pregnancy (teens)	☐ Venereal Disease
☐ Cancer	☐ Fainting	☐ Kidney	☐ Rheumatic fever	☐ Other _____

Please list the name and phone number of the child's physician:

Name of Physician: Phone:

Child's History

Please mark (X) to indicate if the child has or has not had any of the following diseases or problems.

	Yes	No
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?	☐	☐
If yes, please list: _____		
Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	☐	☐
Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	☐	☐
How would you describe the child's eating habits? _____		
Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	☐	☐
Has the child ever been hospitalized?	☐	☐
Does the child have a history of any other illnesses? If yes, please list: _____	☐	☐
Has the child ever received a general anesthetic?	☐	☐
Does the child have any inherited problems?	☐	☐
Does the child have any speech difficulties?	☐	☐
Has the child ever had a blood transfusion?	☐	☐
Is the child physically, mentally, or emotionally impaired?	☐	☐
Does the child experience excessive bleeding when cut?	☐	☐
Is the child currently being treated for any illnesses?	☐	☐
Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	☐	☐
Has the child had any problem with dental treatment in the past?	☐	☐
Has the child ever had dental radiographs (x-rays) exposed?	☐	☐
Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
Has the child had any problems with the eruption or shedding of teeth?	☐	☐
Has the child had any orthodontic treatment?	☐	☐
What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
Does the child take fluoride supplements?	☐	☐
Is fluoride toothpaste used?	☐	☐
How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	☐	☐
Does the child suck his/her thumb, fingers or pacifier?	☐	☐
At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
Does child participate in active recreational activities?	☐	☐

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

PERSONAL GUARANTEE OF PAYMENT
In case any of the above-named individuals or companies fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein incurred.

FINANCIAL POLICY
Payment is expected at the time of service, or you will have to work out an approved payment plan. Accounts more than thirty (30) days old (30 days from the date of service) will have interest added at the rate of ONE AND ONE HALF.PERCENT (11/2) PER MONTH OR 18% PER ANNUM.

Parent's/Guardian's Signature:	Date:

FOR COMPLETION BY DENTIST

Comments: _____

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed by

Date