Child Health/Dental History Form

Patient's Name (LAST FIRST INITIAL)	Nickname	Date of Birth
Parent/Guardian's Name	Relationship to Patient	SSN/SIN
Address (PO OR MAILING / CITY / STATE / ZIPCODE)		
Phone (HOME / WORK)		Sex M □ F □

Responsible Party

Name (LAST FIRST INITIAL)	Relationship to Patient	SSN/SIN
Date of Birth	Drivers License Number	Employer
Address (PO OR MAILING / CITY / STATE / ZIPCODE)		
Phone (HOME / WORK/CELL)		Email

Is this person currently a patient in our office?..... □ Yes □ No

For your convenience we accept the following methods of payment. Please check the option you prefer

□ Cash □ Personal Check □ MasterCard □ VISA □ Discover □ I wish to discuss payment options

Insurance Information

Name of Insured (LAST FIRST INITIAL)	Relationship to Patient	SSN/SIN
Date of Birth	Employer / Date Employed	Union or Local
Address of Employer (CITY / STATE / ZIPCODE)		
Employer Phone Number	Insurance Company / Group Number	Policy/ID Number
Address of Insurance Company (CITY / STATE / ZIPCODE)		

Additional Insurance

Name of Insured (LAST FIRST INITIAL)	Relationship to Patient	SSN/SIN
Date of Birth	Employer / Date Employed	Union or Local
Address of Employer (CITY / STATE / ZIPCODE)		
Employer Phone Number	Insurance Company / Group Number	Policy/ID Number
Address of Insurance Company (CITY / STATE / ZIPCODE)		

Have you (the parent/guardian) or the patient traveled outside of the US in the last 12 months?..... □ Yes □ No

1. Active Tuberculosis □ Yes □ No 2. Persistent cough lasting more than three weeks □ Yes □ No 3. Cough that produces blood □ Yes □ No
4. Fever □ Yes □ No

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

□ Anemia	□ Cancer	□ Epilepsy	□ Kidney	□ Rheumatic Fever
□ Arthritis	□ Cerebral Palsy	□ Fainting	□ Latex Allergy	□ Seizures
□ Asthma	□ Chicken Pox	□ Growth Problems	□ Liver	□ Sickle Cell
□ Bladder	□ Chronic Sinusitis	□ Heart	□ Measles	□ Venereal Disease
□ Bleeding Disorders	□ Diabetes	□ Hepatitis	□ Mononucleosis	□ Cancer
□ Bones/Joints	□ Frequent Ear Aches	□ HIV +/AIDS	□ Mumps	□ Hemophilia
□ Thyroid	□ Tobacco/Drug Use	□ Tuberculosis	□ Asthma	□ Other _____

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

Name of physician _____ Phone_____

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Health History

1. Is the child taking any prescriptions and/or over the counter medications or vitamin supplements at this time?..... □ Yes □ No
ist:_____
2. Has the child ever taken Fen-Phen/Redux?..... □ Yes □ No
3. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain:_____ □ Yes □ No
_____
4. Is the child allergic to anything else? If yes, please explain:_____ □ Yes □ No
5. Has the child ever had a serious illness or injury? If yes when?_____ Please explain:_____ □ Yes □ No
_____
6. Has the child ever been hospitalized? ..... □ Yes □ No
7. Has the child ever received general anesthetic?..... □ Yes □ No
8. Does the child have any speech difficulties?..... □ Yes □ No
9. Is the child physically, mentally, or emotionally impaired?..... □ Yes □ No
10. Does the child experience excessive bleeding when cut?..... □ Yes □ No

Dental History

11.Is this the child's first visit to the dentist? If not, when was the date of the last dental visit? Date:_____ □ Yes □ No
12. Has the child had any difficulties with dental treatment in the past?..... □ Yes □ No
13. Has the child ever had dental radiographs (x-rays)?..... □ Yes □ No
14. Has the child ever had an injury to the mouth, head or teeth?..... □ Yes □ No
15.Has the child had orthodontic treatment?..... □ Yes □ No
16. What type of water does the child drink? □ City Water □ Well Water □ Bottled Water □ Filtered Water
17. Does the child take fluoride supplements? ..... □ Yes □ No
18. Is fluoride toothpaste used?..... □ Yes □ No
19. How many times are the child's teeth brushed per day? _____ Flossed?_____
20. Does the child do any of the following? □ Suck his/her thumb/fingers □ Bite lip □ Bite nails □ Chew on hard objects
ind/ Clench teeth

Sleep History

1. Does this child snore?..... □ Yes □ No
2. Does the snoring occur 2-4 nights per week?..... □ Yes □ No
3.Or does it occur 5-7 nights per week?..... □ Yes □ No
4. Is it interrupted snoring where the child stops □ Yes □ No
breathing?..... □ Yes □ No
5. Does this
seconds or more at least twice per hour?..... □ Yes □ No
6. Is this child hyperactive?..... □ Yes □ No
7. Does this child lack attention or is fidgety?..... □ Yes □ No
8. Does this child have headaches in the morning?.. □ Yes □ No
9. Does this child sweat profusely while sleeping?.. □ Yes □ No
10. Do you have trouble understanding this child's
speech?..... □ Yes □ No
11. Does
like P, B, V, T etc..?..... □ Yes □ No
12. Is this child a restless sleeper?..... □ Yes □ No
13. Does this child look sleepy during the day?..... □ Yes □ No
14. Does this child do poorly in school, particularly in
math or spelling?..... □ Yes □ No
15. Does this child breath through the mouth?..... □ Yes □ No
16. Does this child often wet the bed at night?..... □ Yes □ No
17. Does this child grind their teeth?..... □ Yes □ No
18. Does this child often have nightmares?..... □ Yes □ No

I authorize the dentist to release any information including the diagnosis and the records of treatment or examinations rendered to my child during the period of such care to any third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or dependents.

Signature of Parent/Guardian:_____ Date:_____

Signature of Dentist:_____ Date:_____