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Child Health/Dental History Form

Patient

_____

Last Name First Name Initial Preferred Name

Street Address_____City_____State_____Zip_____

Sex: ___M ___F Age_____ Birthdate_____

Who is responsible for this account?_____ Relationship to Patient_____

Email address_____Cell Phone_____Home Phone_____

Name of Dental Insurance Company_____ Group Number_____ Insured ID _____

In case of emergency, who should be notified? _____Phone_____

Who may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name_____ Date of last physical_____

Has your child ever had any of the following? (Check boxes that apply):

____Anemia	____Cancer	____Epilepsy	____Arthritis
____Cerebral Palsy	____Fainting	____Asthma	____Chicken Pox
____Growth Problems	____Bladder	____Chronic Sinusitis	____Hearing
____Bleeding disorders	____Diabetes	____Heart	____Bones/Joints
____Ear Aches	____Hepatitis	____HIV +/Aids	____Immunizations
____Kidney	____Pregnancy (teens)	____LATEX ALLERGY	____Liver
____Measles	____Mononucleosis	____Mumps	____Rheumatic Fever
____Seizures	____Sickle Cell	____Thyroid	____Tuberculosis
____Venereal Disease			

What type of water does your child drink? ____City water ____Well water ____Bottled water ____Filtered water

Does your child take fluoride supplements?_____ Is fluoride toothpaste used?_____

Does your child have any drug allergies or ever had an adverse reaction to any medication? _____ If so, what?

_____

Has your child ever responded adversely to medical or dental treatment? _____

Is your child taking any medications at this time? ____If so, what?_____

Is your child under the care of a physician? ____Yes____ No For what conditions?_____

What is his/her weight?_____ (Teenage girl) Do you suspect that your daughter is pregnant? ____Yes____No

Is there anything else we should know about your child's medical history? _____

NOTE: Both doctor and patient is encouraged to discuss any and all relevant patient health issues prior to treatment. I, as parent/guardian of my child, have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. The above information is accurate and complete to the best of my knowledge and is only for use in my child's treatment, billing and processing of insurance for benefits which they are entitled. 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.

Date_____Signature_____

Parent if child is under the age of 18