**CHILD/TEEN DENTAL & MEDICAL HEALTH HISTORY**

Name _____ Male/Female (circle one) Birthdate _____

Address _____ City/Zip _____

| **Father's Information** | **Mother's Information** |
|---|---|
| Name _____ | Name _____ |
| Address _____ | Address _____ |
| Phone (H)_____ (C) _____ | Phone (H)_____ (C) _____ |

Do you have dental insurance? YES / NO

**Please provide the receptionist with the name of insurance company, employee, employer, group number, subscriber number and DOB of the subscriber.**

**DENTAL HISTORY**

Date of last visit to a dentist _____ For what? _____

| | | |
|---|---|---|
| Has child complained about dental problems? | YES / NO | If yes:_____ |
| Any unhappy dental experiences?..... | YES / NO | _____ |
| Any injuries to the head, neck or teeth?..... | YES / NO | _____ |
| Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, bottle habits?... | YES / NO | _____ |
| Any unusual speech habits?..... | YES / NO | _____ |
| Any lost teeth (aside from normal growth)?... | YES / NO | _____ |
| Orthodontic appliances worn or recommended? | YES / NO | _____ |
| Does your child brush his/her teeth daily?..... | YES / NO | How often? _____ |
| Does your child use dental floss?..... | YES / NO | _____ |
| Do you assist your child with brushing/flossing? | YES / NO | _____ |
| Is fluoride taken in any form?..... | YES / NO | _____ |
| Does your child drink fluoridated water?..... | YES / NO | _____ |
| Has child ever received local anesthesia?..... | YES / NO | _____ |
| Does child eat between meals?..... | YES / NO | _____ |
| Does child eat sweets such as candy, soda, chewing gum or juice?..... | YES / NO | How much? _____ |

Child's attitude towards dentistry: _____

Do you have any other dental concerns you would like to discuss? _____

_____

***All information will be kept strictly confidential.***

**MEDICAL HISTORY**

Child's Physician _____ Address _____

Date of Last Exam _____ Results _____

Is child under the care of a physician?..... YES / NO If so, for what? _____

Is child receiving medications?..... YES / NO List: _____

Does your child take vitamins or OTC medications? YES / NO List: _____

Is there excessive bleeding when child is injured? YES / NO _____

Has child ever been hospitalized?..... YES / NO Please explain: _____

Has child ever had surgery?..... YES / NO Please explain: _____

Does child have good physical coordination? YES / NO _____

Are there any emotional problems?..... YES / NO _____

Has your child had allergies or adverse reactions to any of the following:

| | | | |
|---|---|---|---|
| Local Anesthetics…… | YES / NO | Aspirin…… | YES / NO |
| Latex…… | YES / NO | Codeine…… | YES / NO |
| Penicillin…… | YES / NO | Ibuprofen…… | YES / NO |
| Erythromycin…… | YES / NO | Other (Please List): | |
| Sulfa Drugs…… | YES / NO | _____ | YES / NO |
| Nickel or other metals…… | YES / NO | _____ | YES / NO |

Has your child had any history or difficulty with the following? (Please check)

| | | | |
|---|---|---|---|
| ____ Anemia | ____ Chronic Sinusitis | ____ Hepatitis | ____ Mumps |
| ____ Asthma | ____ Convulsions | ____ HIV | ____ Rheumatic Fever |
| ____ Autism | ____ Diabetes | ____ Kidney Problems | ____ Thyroid Disease |
| ____ Bladder Issues | ____ Epilepsy | ____ Liver Problems | ____ Tonsillitis |
| ____ Cerebral Palsy | ____ Fainting | ____ Malignancies | ____ Tuberculosis |
| ____ Chicken Pox | ____ Hearing Difficulties | ____ Measles | ____ Other |
| ____ Chronic Ear Infections | ____ Heart Problems | ____ Mononucleosis | |

Please explain any item checked above: _____

_____

Is there any other medical concern we should know about? _____

***To the best of my knowledge, the above information is complete and correct.***

**Signature _____ Relationship _____ Date _____**