PATIENT HEALTH HISTORY FORM

Today's Date _____ Email Address _____

Child's Name _____ Gender_____ Nickname _____ Weight _____

Date of Birth _____

Referred by _____

Parent(s) Name _____

_____

Home Address _____

Parent's Place of Employment _____

Responsibility for Account _____

Date of Birth _____

Dental Insurance Company/Self-Pay _____

Employer _____

SSN# _____

Parent's Occupation _____ Phone _____

Parent's Place of Employment _____ Occupation _____ Phone _____

Name of Person completing form _____ Relationship to Child _____

In case of Emergency please notify _____ Phone _____

Child's Physician _____ Phone _____ Cell _____

MEDICAL AND DENTAL HISTORY

1. Is your child having any dental problems? **Y / N** Please explain _____

2. Is this your child's first visit to any dentist? **Y / N** If not, date of last visit _____

3. Names & Ages of brothers and sisters _____

4. Place of Birth _____ Was water fluoridated? **Y / N** Is it now? **Y / N**

5. Any problems or medications during pregnancy? **Y / N** _____

6. Is your child in good health now? **Y / N** Taking any medication? _____

7. Has your child had any of the following:

____ Heart disease or defects
____ Diabetes
____ Convulsions
____ Kidney Disease
____ Dizziness or Fainting
____ Rheumatic Fever
____ Breathing Difficulties
____ Blood Transfusions
____ Anemia or Blood Disorders
____ Hepatitis or Liver Disease
____ Bleeding Difficulties
____ Birth Defects
____ Hearing Problems
____ Nervous Condition
____ Emotional Problems
____ Frequent Headaches
____ Cleft Palate or Lip
____ Cerebral Palsy
____ Sight Problems
____ Any other illness
____ Delay in Physical or Mental Development

8. Is your child allergic to any food or drugs? **Y / N** (Penicillin, Novocaine, other local anesthetics, aspirin, etc.) _____

9. Has your child ever been warned by a physician against taking any specific drug medication? **Y / N** _____

10. Has your child ever been hospitalized for any reason? **Y / N** When? _____ For what reason? _____

11. Age at which first tooth erupted _____ Did your child ever sleep with a bottle? **Y / N** What did the bottle contain? _____

At what age did he/she stop? _____

Does your child brush his/her own teeth? **Y / N** If not, who does it? _____

Does your child have any speech difficulties?_____

What habits does your child have which might affect the teeth or mouth?

Mouth breather _____ Grinding _____ Clenching _____ Sucks Thumb _____ Sucks Finger _____ Other _____

Has your child had any dental injuries? **Y / N** Explain _____

Has your child ever had fluoride medication at home? **Y / N** Type _____

Diet Summary (frequent and types of sweets) _____

Has your child had any fluoride treatments? **Y / N** Date of last treatment _____

General Dental history of other family members _____

Any other information you feel we should know about your child _____