Child Health History

DATE: _____

PATIENT INFORMATION

Birthdate _____

Name of Minor/Child _____ Preferred Name _____
First Name Last Name Middle Initial

Address _____
Street City State Zip code

Whom may we thank for referring you? _____

PATIENT/GUARDIAN INFORMATION

Please check if you would like this parent to be primary contact for child ☐

Father's/Guardian Name _____
Address (if different form above) _____
_____
Home Phone _____
Cell Phone _____
E-mail _____
Employer _____
Soc. Sec. # _____ Birthdate _____

Please check if you would like this parent to be primary contact for child ☐

Mother's/Guardian Name _____
Address (if different form above) _____
_____
Home Phone _____
Cell Phone _____
E-mail _____
Employer _____
Soc. Sec. # _____ Birthdate _____

DENTAL HISTORY

Date of last visit to a dentist _____ What services were completed? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child floss every day?	☑	☐	Any unhappy dental experiences?	☐	☐
Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottles, etc.?				☐	☐

MEDICAL HISTORY

Physician's Name_____ City/State _____ Phone Number _____
Date of last physical exam _____ Results _____

	YES	NO
Is minor/child under care of a physician now?	☐	☐
Receiving any medications or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____
_____
_____
Allergies _____
_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check mark.

☐ A.I.D.S/H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

AUTHORIZATIONS

To the best of my knowledge, the above information is correct and complete. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

I am the parent, guardian, or personal representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

PARENT/GUARDIAN NAME PRINTED _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____