PEDIATRIC DENTISTRY HEALTH INFORMATION

Date ____________________

Child's Name ________________________________ Nickname ________________________________

Age ________ Birthdate ____________________

School ________________________________ Grade ________________________________

Residence Address ____

City ____________________ Zip Code ____________________ Phone No. ____________________

Father's Name ____________________ Mother's Name ____________________ Brothers _____ Sisters _____

Father's Place of Employment ____________________ Address ____________________

City ____________________ Zip Code ____________ Phone Work ____________ Cell ____________

Mother's Place of Employment ____________________ Address ____________________

City ____________________ Zip Code ____________ Phone Work ____________ Cell ____________

e-mail address ________________________________

Social Security No.: Mr. ____________________ Mrs. ____________________

Child's Favorite Hobby ____________________ Any Pets ____________________

Child's Favorite Sport ____

Person Financially Responsible ____________________ Driver's License No. ____________________

Whom may we thank for referring ____

Reason for appointment ____

FOR PATIENTS WITH DENTAL INSURANCE

Dental Insurance Carrier: (Mr.) ____________________ (Mrs.) ____________________

Carrier Address ____ Group No. ____________

If patient is a student, name of school: ________________________________

If student is over age 19 verification of student status required for insurance coverage.

Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this and because of the extreme delay in receiving payment from insurance companies, you will be asked to pay a percentage of the charges before your treatment is completed. Insurance will be sent in for you, and if we do not receive payment from them within 45 days then the account is your responsibility.

Signature ____

DENTAL HISTORY

Date of last dental visit ____________________

For what ____________________

By Dr. ____________________

Any previous unhappy medical or dental visits? ____________________ yes/no

Has your child complained about any dental problems? ____________________ yes/no

Any injuries to mouth, teeth, head? ________ yes/no

____

Any mouth habits: thumbsucking, nail biting, mouthbreathing, etc.? ____________________ yes/no

____

Any lost teeth? ____________________ yes/no

Does your child brush daily? ____________________ yes/no

Do you assist your child with brushing? ____ yes/no

How often? ____________________

Is dental floss used? ____________________ yes/no

How does your child receive flouride? ______

____

Water supply? ____ Toothpaste? ____

Dentist? ____ Vitamin? ____ None? ____

Other? ____________________

Child's attitude to dentistry: ____________________

____

____

____

MEDICAL HISTORY

Child's Physician ______________ Address ______________ Phone ______

Date of last examination? ______________ Results? ______________

Is your child in good health? ______________

Is your child presently under care by a physician? ______________

Is your child receiving any medications or drugs? ______________

What is your child's weight? ______________ height? ______________

Has your child ever been hospitalized? ______________

Eating habits presently — briefly explain ______________

Are there any psychological or emotional problems you would like to bring to our attention? ______________

____

____

DOES YOUR CHILD HAVE OR HAS HE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

	yes	no
1. RHEUMATIC FEVER or RHEUMATIC HEART DISEASE	☐	☐
2. CONGENITAL HEART DISEASE OR HEART MURMUR	☐	☐
3. ALLERGIES: A) FOOD, DUST, ETC. ______	☐	☐
B) DRUG, i.e. Penicillin, etc. ______	☐	☐
C) UNKNOWN ______	☐	☐
4. ASTHMA or HAY FEVER ______	☐	☐
5. ARTHRITIS or RHEUMATISM (PAINFUL SWOLLEN JOINTS) ______	☐	☐
6. DIABETES or BLOOD SUGAR PROBLEMS ______	☐	☐
7. ANY PROLONGED BLEEDING or BRUISES EASILY ______	☐	☐
8. KIDNEY or BLADDER PROBLEMS ______	☐	☐
9. ANEMIA or BLOOD DISORDERS ______	☐	☐

	yes	no
10. TUBERCULOSIS or PNEUMONIA ______	☐	☐
11. LIVER PROBLEMS, JAUNDICE or HEPATITIS ______	☐	☐
12. GLANDULAR or HORMONAL PROBLEMS ______	☐	☐
13. ACCIDENTS or SEVERE INFECTIONS ______	☐	☐
14. CONVULSION, SEIZURES, FAINTING or EPILEPSY ______	☐	☐
15. HIGH/LOW BLOOD PRESSURE ______	☐	☐
16. SPEECH, LEARNING or HEARING DISORDERS ______	☐	☐
17. CHILDHOOD ILLNESSES ______	☐	☐
18. IMMUNIZATIONS ______	☐	☐
19. OTHER, IF SO EXPLAIN ______	☐	☐

IF YES, PLEASE EXPLAIN ______________

____

____

SUMMARY: (FOR DOCTOR'S USE)

I hereby certify the foregoing information is correct and true. Because ______________ is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Authorization is hereby granted as such.

Furthermore, I will be responsible for any professional fees incurred for dental services to my child.

Signed ______________ Date ______________