

# HEALTH HISTORY AND PATIENT INFORMATION

Who may we thank for referring you to our office? \_\_\_\_\_

## PERSONAL INFORMATION

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street City State Zip Code

Telephone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Name of Parent(s) / Responsible Guardian(s) \_\_\_\_\_ SS# \_\_\_\_\_

Name of Emergency Contact (other than parent/guardian) \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name of child's physician \_\_\_\_\_ Date last seen \_\_\_\_\_

Reason for bringing the child to the dentist \_\_\_\_\_

## INSURANCE INFORMATION

Is your child covered by a dental insurance plan? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of insurance \_\_\_\_\_ Group / Policy # \_\_\_\_\_

Name of parent/guardian insured \_\_\_\_\_ Social Security # of parent/guardian \_\_\_\_\_

Date of birth of parent/guardian \_\_\_\_\_ Has the child received previous dental care under this plan Yes \_\_\_\_\_ No \_\_\_\_\_

## HISTORY

YES                      NO

- |   |                          |                          |  |
|---|--------------------------|--------------------------|--|
| 1. Has your child ever required hospitalization for more than 24 hours?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 2. Has your child ever received general anesthesia?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 3. Does your child have any food or medication allergies?<br>If yes, what? _____  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 4. Is your child currently taking any medications?<br>If yes, what? _____   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 5. Has your child ever been seen by a dentist before?<br>If yes, when was their last visit? _____<br>Name of the doctor _____ | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 6. Has your child ever received any form of fluoride?<br>If yes, what? _____  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 7. Does your child suck his/her thumb/fingers or a pacifier?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 8. Are your child's teeth brushed daily?<br>If yes, how many times? _____   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 9. Does your child use toothpaste<br>If yes, what kind? _____   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 10. Is your child still bottle/breast feeding?<br>If no, at what age did he/she stop? _____                                   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 11. Please provide the names and ages of your other children _____<br>_____   |                          |                          |  |

**Has your child had any medical problems in the following areas? Please check all that apply.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Blood                    | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Muscles          |
| <input type="checkbox"/> Bones                    | <input type="checkbox"/> Heart            | <input type="checkbox"/> Nervous system   |
| <input type="checkbox"/> Endocrine                | <input type="checkbox"/> Kidney/bladder   | <input type="checkbox"/> Skin             |
| <input type="checkbox"/> Eyes, ears, nose, throat | <input type="checkbox"/> Liver            | <input type="checkbox"/> Tonsils/adenoids |

This child had NOT had treatment for any of the above.

**Has a physician ever diagnosed this child with any of the following medical conditions? Please check all that apply.**

- |                                       |  |   |   |   |
|---------------------------------------|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD     | <input type="checkbox"/> Cerebral Palsy        | <input type="checkbox"/> Eye problems       | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Rheumatic fever    |
| <input type="checkbox"/> Allergy      | <input type="checkbox"/> Cleft lip/palate      | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Scoliosis          |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Convulsions/ seizures | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Mental retardation     | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Developmental delay   | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Spina Bifida       |
| <input type="checkbox"/> Autism       | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Heart disease      | <input type="checkbox"/> HIV                    | <input type="checkbox"/> Syndrome           |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Emotional disturbance | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Nutritional deficiency | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Hemophilia         | <input type="checkbox"/> Orthopedic problems    |   |

This child has never been diagnosed with any of the above conditions.

Is there anything else you think we should know about this child so that we may better meet his treatment needs? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Relationship to the patient

\_\_\_\_\_  
Date

**DO NOT WRITE BELOW THIS LINE**

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**Medical History Summary**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SBE Recommendations**

\_\_\_\_\_

\_\_\_\_\_

**Dental History Summary**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date