Patient #_____

Date_____

PATIENT NAME_____

Health History

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Has your child had any difficulty with previous dental visits ❑ YES ❑ NO If yes, please explain: _____

_____

Has your child ever had any of the following? If yest list below *

Asthma	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No	Behavioral Issues	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Congenital Heart Defect	❑ Yes	❑ No	Breathing Problems	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	Handicaps/Disabilities	❑ Yes	❑ No	Hospital or ER Visits	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No	Convulsions/Epilepsy	❑ Yes	❑ No	ADD	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No	ADHD	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Abnormal Bleeding	❑ Yes	❑ No	Autism	❑ Yes	❑ No
Allergies-Seasonal	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No			
Medication Allergies	❑ Yes	❑ No						

* If yes to any of the above, please explain_____

_____

Please explain any medical problems or changes in your child's health_____

_____

Please explain any current dental problems or difficulties_____

_____

Present medications including vitamins or fluoride tablets_____

Why?_____

Child's Habits

Is this your child's first dental visit?_____

How often does your child brush?_____

How often does your child floss?_____

Date of last dental visit_____

Name of previous dentist_____

Child's Physician_____

Phone Number_____

Child's Birthdate_____

Is your child's water fluoridated? ❑ Yes ❑ No

Does your child take fluoride supplements? ❑ Yes ❑ No

Does your child:

Suck thumb/finger	❑ Yes	❑ No
Suck/bite lips	❑ Yes	❑ No
Bite/chew nails	❑ Yes	❑ No
Chew hard objects-pencils-etc.	❑ Yes	❑ No
Grind Teeth	❑ Yes	❑ No
Clench Jaws	❑ Yes	❑ No

Any specific questions or concerns?_____

_____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient or parent if minor — Date

Dentist's Review

_____

_____

_____

_____

Date_____

Signed Dr._____

Health History Update

Date_____Comments_____

_____

Signature_____

Date_____Comments_____

_____

Signature_____