

Child Health History

Child's Name _____

Birth date _____ Phone # _____

Is the child under the care of a Physician? yes no

Why? _____

What medications is the child currently taking?

Is the child allergic to any medications or substances?

Aspirin Codeine Penicillin Latex Sulfa

Jewelry/Metals Other _____

Has the child been instructed to pre-medicate with

antibiotics before receiving dental care? yes no

Has the child experienced any of the following?

	Yes	No		Yes	No
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Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/ Tumors	<input type="checkbox"/>	<input type="checkbox"/>
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Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
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Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Jaw joint problems	<input type="checkbox"/>	<input type="checkbox"/>
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Any heart problem	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ seizures	<input type="checkbox"/>	<input type="checkbox"/>
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Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/ Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
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AIDS/ HIV	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
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Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
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Please list any medical condition not listed above.

Child Dental History

Reason for today's visit? _____

Describe any dental problems that the child may have _____

When was the child's last dental check-up? _____ When was a panoramic x-ray taken? _____

Are you concerned that the child may need orthodontics? yes no Has the child seen an orthodontist? yes no

How would you rate the child's tooth brushing? good fair poor very poor

How often does the child brush? _____ Does the child use a power tooth brush? yes no

Does the child have any of the following habits? (please check)

- | | | |
|--|---|---|
| <input type="checkbox"/> Drinks soda daily | <input type="checkbox"/> Chews gum / eats candy | <input type="checkbox"/> Sucks thumb or pacifier |
| <input type="checkbox"/> Eats sweets between meals | <input type="checkbox"/> Uses breath mints | <input type="checkbox"/> Goes to bed without brushing |

Other concerns _____

Does the child play sports? yes no Does the child wear a protective mouth guard? yes no

Type of water the child drinks? City water Well water Bottled water w/ fluoride Bottled water w/o fluoride

Are fluoride supplements taken? yes no

Is there any additional information that we should know about the child? _____

I understand that the information I have given is correct. I authorize treatment of required dental services and release of information for medical consultation and referral, as well as insurance submission. I also understand that it is my responsibility to inform this office of any changes the child's medical status.

(Signed)

(Relationship to the child)

(Date)