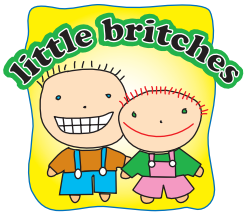

HEALTH HISTORY FORM

CHILD'S INFORMATION

Child's Name _____

Date of Birth _____ Gender _____ Age _____

We care about your child's health and want to create a "dental home" where your child is comfortable and feels supported. Please fill out this Dental & Medical History to help us provide the best possible care.

DENTAL HISTORY

Has your child ever been to the dentist before? ☐ YES ☐ NO

(if YES answer the following questions, if NO or if you are an existing patient skip to Question 7)

1. When was his/her last visit to the dentist? .....

   Were x-rays taken at his/her last visit? ☐ YES ☐ NO
2. Has your child had any cavities in the past? ☐ YES ☐ NO
3. Has he/she had any problems with dental treatment in the past? ☐ YES ☐ NO
4. Has your child had any teeth removed by extraction in the past? ☐ YES ☐ NO

   For what purpose? _____

   Was a space maintaining appliance placed? ☐ YES ☐ NO
5. Has he/she ever had sealants placed by a dentist? ☐ YES ☐ NO
6. Has your child had a negative dental experience in the past? ☐ YES ☐ NO
7. How often does your child eat sweets? (Candy, Soda, Cookies, etc) ☐ Rarely ☐ Once a day ☐ Frequently
8. How many times a day does your child brush his/her teeth? _____
9. When does your child brush his/her teeth?

   ☐ Morning ☐ After eating any food ☐ After meals ☐ Before going to bed
10. Does your child have bad breath? ☐ YES ☐ NO
11. Is your child a mouth breather? ☐ YES ☐ NO
12. Has your child ever had cold sores? ☐ YES ☐ NO
13. Does your child suck his/her thumbs, fingers or a pacifier? ☐ YES ☐ NO
14. Has he/she ever experienced any dental injuries? ☐ YES ☐ NO If so describe _____
15. Has anyone in the family, including parents received orthodontic treatment? ☐ YES ☐ NO
16. Has your child ever had local anesthetic? ☐ YES ☐ NO

    If yes how did he/she do? _____
17. Do you or your child have any concerns about his/her teeth? ☐ YES ☐ NO

    If yes please explain _____
18. What is most important to you about your child's dentist and dental care? _____

_____

_____

HEALTH HISTORY FORM

CHILD'S INFORMATION

Child's Name _____ Date of Birth _____

Name of Physician and Practice Name:_____Physician's Phone:_____

MEDICAL HISTORY

1. Does your child have any health problems we should be aware of?..... ☐ YES ☐ NO

   If yes please explain_____

2. Is he/she under the care of a physician now? ..... ☐ YES ☐ NO

   If yes please explain_____

   Physician name _____

   Phone number _____

3. Is he/she currently taking any medications?..... ☐ YES ☐ NO

   Please list all medications _____

4. Does your child have any allergies? ☐ YES ☐ NO

   Please list _____

5. Has your child had any serious illness? ..... ☐ YES ☐ NO

   If so, please explain: When _____ What _____

Please check all that apply and add relevant explanations:

- ☐ Penicillin Allergy
- ☐ Antibiotic Allergy
- ☐ Sulfa Allergy
- ☐ Latex Allergy
- ☐ Allergy to Metal
- ☐ Gluten Allergy
- ☐ Nut Allergy
- ☐ Other Allergy
- ☐ Hospitalizations /Stays/NICU
- ☐ Surgery
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Congenital Birth Defect
- ☐ Developmental Delay
- ☐ Down Syndrome
- ☐ Mental Illness
- ☐ Sensory Issues
- ☐ Speech Impairment
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Murmur
- ☐ Hearing Loss
- ☐ Liver Problems
- ☐ Kidney Problems
- ☐ Obesity
- ☐ Severe/Prolonged Bleeding
- ☐ History of Fainting /Dizziness
- ☐ History of Seizures
- ☐ AIDS or HIV Positive
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Rheumatic Fever
- ☐ Other Disease

Explanations: _____

_____

The information I have provided above is complete and accurate.

_____ _____

Responsible Party Date