PERSONAL **PATIENT HISTORY** DATE _____

Child's Name _____ Nickname (if any) _____
First Middle Last

Date of Birth _____ Age ____ Sex: M F School _____ Grade _____

Home Address _____ City _____ State _____ Zip _____

Name and Age of Siblings _____

Interests or hobbies: _____

Parent's Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Mother's Name _____ Social Security # _____ D.O.B. _____

Home Phone # _____ Cell # _____ Email _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Bus. Phone # _____

Business Address _____ City _____ State _____ Zip _____

Father's Name _____ Social Security # _____ D.O.B. _____

Home Phone # _____ Cell # _____ Email _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Bus. Phone # _____

Business Address _____ City _____ State _____ Zip _____

Whom May We Thank for Referring You? _____

HEALTH INSURANCE INFORMATION

Dental Coverage ☐

Subscriber (covered employee) _____

Employer providing insurance: _____

Name of insurance carrier (company): _____

Group or Policy # _____

Medical Coverage ☐

Subscriber (covered employee) _____

Employer providing insurance: _____

Name of insurance carrier (company): _____

Group or Policy # _____

MEDICAL HISTORY

Child's Physician _____ Address _____ Phone # _____

Date of last physical examination? _____ Results _____

Is a physician treating your child now for a specific illness? ..... Yes No

If so, for what reason? _____

Is your child taking any medication at this time? ..... Yes No

Drug	Dose	Frequency	Reason

Has your child shown any allergies or unusual reactions?

a) Medications or drugs _____

b) Foods _____

c) Other _____

Were there any problems with the birth or pregnancy? ..... Yes No

Did child go home with mother from the hospital? ..... Yes No

Has your child ever been hospitalized? If so, ... Yes No

When? _____

For what reason? _____

Has your child had any operations? If so, ... Yes No

When? _____

For what reason? _____

Are there any psychological or emotional problems you would like to bring to our attention? ..... Yes No

Does your child have any history of the following diseases or conditions?

- ☐ Accidents or Severe Infections
- ☐ ADD/ADHD
- ☐ AIDS or AIDS Related Symptoms, HIV+
- ☐ Anemia or Blood Disorders
- ☐ Asthma or Lung Problems
- ☐ Autism
- ☐ Bleeding Problems
- ☐ Blood Transfusions
- ☐ Cerebral Palsy
- ☐ Convulsion, Seizures, or Epilepsy
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart Murmur, Congenital Heart Disease
- ☐ Intellectual Disability
- ☐ Kidney or Bladder Problems
- ☐ Liver Problems, Jaundice or Hepatitis
- ☐ Malignancies
- ☐ Speech, Learning, or Hearing Disorder
- ☐ Vision Problems
- ☐ Other, if so explain

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION DENTIST SHOULD BE AWARE OR THAT HAS **NOT** BEEN COVERED ABOVE.

_____

DENTAL HISTORY

Why did you make this appointment? _____

_____

Is this your child's first visit to a dentist? Yes No

If not, how long since the last dental visit? _____

Child's previous dentist:

Name _____

Address _____

Approximate date of last dental "x-rays" _____

Has your child ever had any unpleasant dental experience? Yes No

If so, please explain: _____

Does your child have any of the following habits? (indicate ages when occurred)

Bottle to bed at night or nap _____

What was in bottle? _____

Use a pacifier? _____

Thumb or finger sucking _____

Tongue thrusting _____

Lip sucking or biting _____

Mouth breathing _____

Grinds Teeth _____

Does your child brush his/her own teeth? ..... Yes No

How frequently and when? _____

Do you brush your child's teeth? ..... Yes No

How frequently and when? _____

Do you or your child use dental floss in cleaning your child's teeth? ..... Yes No

How frequently and when? _____

Has your child had fluoride in any of the following forms?

Fluoride tablets or in multiple vitamins ..... Don't know Yes No

Drinking water (community fluoridation) ..... Don't know Yes No

Topical application on teeth (please circle) Dentist applied, Home rinse, Home brush-on gel, School rinse

Toothpaste; brand _____

Have your child's teeth ever been injured? ..... Yes No

When? _____

Which Teeth? _____

Cause? _____

Were the teeth treated? ..... Yes No

If so describe treatment _____

Does your child tend to complain of clicking, popping or crunching noises in his/her ears while chewing? ..... Yes No

The signature of a parent or guardian affixed below authorizes the completion of all mutually agreed upon necessary dental services.

Signature _____ Relationship _____ Date _____

SUMMARY: (FOR DOCTOR'S USE) REVIEWER: _____ DATE: _____

MEDICAL

DENTAL