Health History

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

Health History

Has your child had difficulty with previous visits?_____

Does your child have history of allergies to any substances (latex, environmental, etc.)? _____

Has your child ever had any of the following:

Acid Reflux ☐ YES ☐ NO
Allergies ☐ YES ☐ NO
Anemia ☐ YES ☐ NO
Asthma ☐ YES ☐ NO
Blood Transfusion ☐ YES ☐ NO
Cancer ☐ YES ☐ NO
Convulsions/Epilepsy ☐ YES ☐ NO
Diabetes ☐ YES ☐ NO
Handicaps/Disabilities ☐ YES ☐ NO
Hearing Impairment ☐ YES ☐ NO
Heart Problems ☐ YES ☐ NO
Hemophilia/Abnormal Bleeding ☐ YES ☐ NO
Hepatitis ☐ YES ☐ NO
HIV/AIDS ☐ YES ☐ NO
Persistent Cough ☐ YES ☐ NO
Rheumatic Fever ☐ YES ☐ NO
Tuberculosis ☐ YES ☐ NO

Please explain any medical problems that your child has

_____

_____

_____

_____

_____

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

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

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/guardian if minor

_____

Date

Dentist's Review

_____

_____

_____

_____

Date _____

Signed Dr. _____

Health History Update

Date _____

Comments _____

_____

Signature _____

Date _____ Comments _____

_____

Signature _____