

# 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 <input type="checkbox"/> YES <input type="checkbox"/> NO            | Hearing Impairment <input type="checkbox"/> YES <input type="checkbox"/> NO           |
| Allergies <input type="checkbox"/> YES <input type="checkbox"/> NO              | Heart Problems <input type="checkbox"/> YES <input type="checkbox"/> NO               |
| Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO                 | Hemophilia/Abnormal Bleeding <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO                 | Hepatitis <input type="checkbox"/> YES <input type="checkbox"/> NO                    |
| Blood Transfusion <input type="checkbox"/> YES <input type="checkbox"/> NO      | HIV/AIDS <input type="checkbox"/> YES <input type="checkbox"/> NO                     |
| Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO                 | Persistent Cough <input type="checkbox"/> YES <input type="checkbox"/> NO             |
| Convulsions/Epilepsy <input type="checkbox"/> YES <input type="checkbox"/> NO   | Rheumatic Fever <input type="checkbox"/> YES <input type="checkbox"/> NO              |
| Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO               | Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO                 |
| Handicaps/Disabilities <input type="checkbox"/> YES <input type="checkbox"/> 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

## Health History Update

Date \_\_\_\_\_

Comments \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Comments \_\_\_\_\_

Signature \_\_\_\_\_

## Dentist's Review

Date \_\_\_\_\_

Signed Dr. \_\_\_\_\_