# Health History

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

## Health History

Has your child had any difficulty with previous dental visits?

Comments: _____

Has your child ever had any problems with:

| | | |
|---|---|---|
| Allergies | ❑ yes | ❑ no |
| Congenital birth defects | ❑ yes | ❑ no |
| Congenital heart defects | ❑ yes | ❑ no |
| Seizures | ❑ yes | ❑ no |
| Recurrent/frequent headaches | ❑ yes | ❑ no |
| Mental and physical developmental delays | ❑ yes | ❑ no |
| Behavioral/learning problems | ❑ yes | ❑ no |
| History of blood transfusions and date | ❑ yes | ❑ no |
| History of abnormal bleeding/Hemophilia | ❑ yes | ❑ no |
| Heart murmur | ❑ yes | ❑ no |
| Kidney | ❑ yes | ❑ no |
| Liver/GI system/Hepatitis | ❑ yes | ❑ no |
| Diabetes/Thyroid disease | ❑ yes | ❑ no |
| Breathing/Lung/Asthma | ❑ yes | ❑ no |
| Blood disorders | ❑ yes | ❑ no |
| Cancer/tumors | ❑ yes | ❑ no |
| Hearing | ❑ yes | ❑ no |
| Sight | ❑ yes | ❑ no |
| Frequent infections/Autoimmune | ❑ yes | ❑ no |
| Significant injuries | ❑ yes | ❑ no |
| HIV/Aids | ❑ yes | ❑ no |
| Social development (personality/ temperament) | ❑ yes | ❑ no |
| Hospitalizations | ❑ yes | ❑ no |

Name of Physician/date of last physical exam: _____

_____

Please list any of other medical problems that your child has:

_____

Please list any medications your child is currently taking:

_____

Please list any medications your child is allergic to: _____

_____

Please explain any other medical problems that your child has: _____

## Dental History

Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

Previous Dentist _____

Phone Number _____

What age did bottle use stop? _____

| | | |
|---|---|---|
| Is your child's water fluoridated? | ❑ yes | ❑ no |
| Does your child take fluoride supplements? | ❑ yes | ❑ no |
| Does your child suck thumb/finger? | ❑ yes | ❑ no |
| Bite/chew nails? | ❑ yes | ❑ no |
| Grind teeth? | ❑ yes | ❑ no |
| Pain in TMJ? | ❑ yes | ❑ no |
| History of trauma to teeth? | ❑ yes | ❑ no |

Referred by _____

## Dentist's Review

**(For Doctor's Use Only)**

_____

_____

_____

_____

_____

_____

_____

Date _____ Signed Dr. _____

## 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 payers 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 if minor — date