Child Patient Health History

Child information

Your Child: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Birth Date: _____

Phone (Home): _____ School: _____ Grade: _____

Health Information

Has your child ever had any of the following? Please check those that apply:

MEDICAL HISTORY

- ☐ ADHD or other neurologic condition
- ☐ AIDS/HIV
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune Disorders
- ☐ Behaviorial or conduct issues
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Eye Disorders
- ☐ Frequent urination
- ☐ GI disorders / reflux / ulcers /abdominal pain
- ☐ Handicaps/ Disabilities
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur / MVP
- ☐ Hepatitis / Jaundice
- ☐ Hives or a skin rash
- ☐ Inflammatory joint disorder
- ☐ Immune Disorders
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disorders
- ☐ Migraine headaches
- ☐ Persistant Cough
- ☐ Shortness of breath after mild exercise
- ☐ Sinus trouble
- ☐ Speech delay
- ☐ Tuberculosis

DRUG ALLERGIES

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Drug Allergies

ALLERGIC REACTIONS

- ☐ Local Anesthetics
- ☐ Latex
- ☐ Aspirin or other analgesics
- ☐ Sedatives

Has your child ever had abnormal bleeding with previous extractions, surgery, or trauma? ☐ Yes ☐ No

Has child had surgery or x-ray treatment for a tumor, growth, or other conditions? ☐ Yes ☐ No

Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Is your child under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

☐ Prescribed Medications: _____

Does your child have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Date of Last Dental Visit: _____ Reason for that visit: _____

Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Does your child currently have braces or wear a retainer? ☐ Yes ☐ No Planned date of braces removal _____

What past dental experiences has your child had? _____

Please let us know any other information that may help us to provide your child with optimum dental care:

_____

Consent for Services

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my child's health. It is my responsibility to inform your office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/ or other health practitioners.

_____ Date: _____ Relationship to Patient: _____
Signature of Parent or Guardian