

# CHILD'S INFORMATION AND HEALTH HISTORY

## INITIAL EXAM

DATE \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(NICKNAME IF ANY)

CHILD'S ADDRESS \_\_\_\_\_ CHILD'S PHONE \_\_\_\_\_

HOBBIES, SPORTS AND INTERESTS \_\_\_\_\_  
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PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RESIDENCE PHONE \_\_\_\_\_

RESIDENCE ADDRESS \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ SS # \_\_\_\_\_

DENTAL INSURANCE PLAN (IF ANY) \_\_\_\_\_ REFERRED BY \_\_\_\_\_

PATIENT'S NAME

## DENTAL HISTORY

CHIEF ORAL COMPLAINT \_\_\_\_\_

DATE OF LAST DENTAL EXAM. \_\_\_\_\_ ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE,  YES  NO EXPLAIN \_\_\_\_\_

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Traumatic injury to mouth or teeth                | <input type="checkbox"/> Bad breath   | <input type="checkbox"/> Texture of toothbrush _____    |
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure | <input type="checkbox"/> Complications from extractions                                   | <input type="checkbox"/> Frequency of brushing _____    |
| <input type="checkbox"/> Bleeding gums. How long _____                     | <input type="checkbox"/> Topical Fluoride Treatment                                       | <input type="checkbox"/> Dental Floss                   |
| <input type="checkbox"/> Food impaction                                    | <input type="checkbox"/> Orthodontic treatment  | <input type="checkbox"/> Disclosing tablets or solution |
| <input type="checkbox"/> Clenching or grinding of teeth                    | <input type="checkbox"/> Mouth breathing  | <input type="checkbox"/> Fluoride supplements           |
| <input type="checkbox"/> Swelling or lumps in mouth                        | <input type="checkbox"/> Oral habits; thumbsucking, fingernail biting, cheek biting, etc. | <input type="checkbox"/> Between meal snacks            |
| <input type="checkbox"/> Frequent blisters on lips or mouth                |   | <input type="checkbox"/> Well balanced diet             |
| <input type="checkbox"/> Pain around ear                                   |   |   |

## MEDICAL HISTORY

PHYSICIAN'S NAME \_\_\_\_\_ DATE OF LAST PHYSICAL EXAM. \_\_\_\_\_ CHILD'S AGE \_\_\_\_\_

DOES THE CHILD HAVE OR HAS THE CHILD HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergy to Penicillin                     | <input type="checkbox"/> Hay fever or allergies in general        | <input type="checkbox"/> Sinus problems                      |
| <input type="checkbox"/> Allergies to other drugs                  | <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Physical or mental handicap         |
| <input type="checkbox"/> Allergies to anesthetics                  | <input type="checkbox"/> Kidney problems                          | <input type="checkbox"/> Thyroid disorders                   |
| <input type="checkbox"/> Any heart ailments                        | <input type="checkbox"/> Liver problems or hepatitis              | <input type="checkbox"/> Eye disorders                       |
| <input type="checkbox"/> Radiation Treatments                      | <input type="checkbox"/> Malignancies or Leukemia                 | <input type="checkbox"/> Tonsillitis                         |
| <input type="checkbox"/> Excessive bleeding from cut or extraction | <input type="checkbox"/> Psychiatric care/emotional problems      | <input type="checkbox"/> Ulcer or colitis                    |
| <input type="checkbox"/> Anemia or blood problems                  | <input type="checkbox"/> Rheumatic fever                          | <input type="checkbox"/> Extreme nervousness or apprehension |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Immune System Disorders (AIDS, HIV, ARC) | <input type="checkbox"/> Other _____                         |

Describe any current medical treatment including drugs taken, even though not listed above \_\_\_\_\_  
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APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for the patient.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We will prepare necessary forms or reports to help the persons responsible to obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.