PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Patient Name _____ SS#_____ Date_____

Age_____ Date of birth_____ Sex_____ Race_____ School_____

Parent/Guardian_____ Phone #_____ Work#_____

Address_____ City_____ State_____ Zip_____

Brothers_____ Sisters_____ Pets_____

Name of Child's Physician_____ Date last seen_____

In emergency, please write name and phone number of someone other than a person who lives with you:

Name:_____ Phone #_____

AUTHORIZATION & FINANCIAL RESPONSIBILITY:

1. Person responsible for child's financial support:_____

   Address_____ Phone #_____

   Employer_____ Phone #_____

2. Is your child covered by a dental insurance plan? Yes_____ No_____

   Insured's name & DATE OF BIRTH_____ SS#_____

   Name of insurance company_____ Group/ Policy #_____

   Has your child received previous dental care under this plan? Yes_____ No_____

3. Is your child eligible for state medical assistance? Yes_____ No_____

4. Reason for bringing child to the dentist_____

5. Whom may we thank for referring you?_____

HISTORY:

1. Is your child being treated by a physician at this time? Yes No
   If yes, why?_____
2. Has your child ever been a patient in a hospital? Yes No
   If yes, why?_____
3. Has your child ever received general anesthesia or sedation? Yes No
   If yes, when?_____
4. Is your child allergic to anything? (food or medicine) Yes No
   If yes, what?_____
5. Is your child taking any medication at this time? Yes No
   If yes, what?_____
6. Has your child ever been seen by a dentist before? Yes No X-rays? Yes No
   Date last seen_____ Dentist's name_____
7. Has your child ever received fluoride in any form? Yes No
   If yes, what?_____
8. Does your child suck his/her thumb or fingers? Yes No
9. Are your child's teeth brushed once or more a day? Yes No

ORGANS AND SYSTEMS:

Has this child ever had treatment for any of the following? Please check yes or no.

Yes	No		Yes	No		Yes	No	
☐	☐	Blood Circulatory	☐	☐	Gastrointestinal-Stomach	☐	☐	Muscles
☐	☐	Blood Transfusion	☐	☐	Kidney-Bladder	☐	☐	Nervous System
☐	☐	Bones	☐	☐	Heart	☐	☐	Respiratory-Lungs
☐	☐	Endocrine Glands	☐	☐	Heart murmur	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils-Adenoids

ILLNESS:

Has this child ever been diagnosed as having any of the following conditions? Please check yes or no.

Yes	No		Yes	No		Yes	No	
			☐	☐	Eye Problems			
☐	☐	AIDS	☐	☐	Excessive Bleeding	☐	☐	Psychiatric Disorder
☐	☐	Anemia	☐	☐	Fainting	☐	☐	Rheumatic Fever
☐	☐	Allergy	☐	☐	Hearing Loss	☐	☐	Scarlet Fever
☐	☐	Arthritis	☐	☐	Heart Disease	☐	☐	Scoliosis
☐	☐	Asthma	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia
☐	☐	Autism	☐	☐	Hepatitis Type _____	☐	☐	Sinus Problems
☐	☐	Brain Injury	☐	☐	Jaundice	☐	☐	Snoring at night
☐	☐	Bronchitis	☐	☐	Leukemia	☐	☐	Sore Throats-frequent
☐	☐	Cancer	☐	☐	Measles	☐	☐	Spina Bifida
☐	☐	Cerebral Palsy	☐	☐	Mental Retardation	☐	☐	Syndrome _____
☐	☐	Chicken Pox	☐	☐	Mumps	☐	☐	Tetanus
☐	☐	Cleft Lip-Palate	☐	☐	Mouth Breathing	☐	☐	Tuberculosis
☐	☐	Convulsions-Seizures	☐	☐	Nutritional Deficiency	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Orthopedic Problems	☐	☐	Whooping Cough
☐	☐	Diphtheria	☐	☐	Pneumonia	☐	☐	Latex Allergy
☐	☐	Drug or Alcohol Abuse	☐	☐	Polio	☐	☐	ADD-ADHD
☐	☐	Epilepsy	☐	☐	Pregnancy	☐	☐	Disorders _____

Is there anything else that you think we should know about your child?

_____

_____

_____

I certify that I have read and understand the above questions. I will not hold Dr. Davis and his Associates or any member of their staff responsible for any errors or omissions I may have made in this form.

_____
Signature of person completing form

_____
Relationship to patient

_____
Mother's Name

_____
Father's Name