# PATIENT HEALTH HISTORY

| Child's name: Last: | First: | Middle: | Birth date: |
|---|---|---|---|
| Child's Physician: | | Physician's Phone #: | |
| Date of last physical exam: | | Results: | |
| Is child under care of physician now? Y N | | If yes, why? | |
| Receiving any medications or drugs? Y N | | If yes, why? | |
| Ever been hospitalized? Y N | | If yes, why? | |
| Ever had surgery? Y N | | If yes, why? | |

## Has child had any history or difficulty with the following? Please (circle) Yes or No.

| | | | |
|---|---|---|---|
| Y N A.I.D.S./H.I.V. | Y N Cerebral Palsy | Y N Hay Fever | Y N Mental Disability |
| Y N Anemia | Y N Cleft Lip/Palate | Y N Hearing Problems | Y N Rheumatic Fever |
| Y N Bladder Problems | Y N Convulsions | Y N Heart Problems | Y N Sinus Problems |
| Y N Blood Transfusion | Y N Developmental Disability | Y N Hepatitis | Y N Thyroid Disease |
| Y N Bruise Easily | Y N Diabetes | Y N Jaundice | Y N Tuberculosis |
| Y N Cancer | Y N Epilepsy | Y N Kidney Disease | Y N Premature |
| Y N Skeletal problems | Y N Fainting | Y N Liver Disease | Other |

| | |
|---|---|
| Any medications taken? | Has child ever had any asthmatic attacks? Y N<br>If yes, Mild Moderate Severe Frequency? |
| Comments: | |

## Is child allergic to, or ever had an adverse reaction to the following? Please (circle) Yes or No.

| | | | | |
|---|---|---|---|---|
| Y N Penicillin | Y N Local Anesthetics | Y N General Anesthesia | Y N Latex | Other: (please list) |
| Y N Amoxicillin | Y N Sedatives | Y N Sulfa Drugs | | |

# DENTAL HISTORY

| | | |
|---|---|---|
| Is this your child's first visit to a dental office? Y N If no, please complete the following: | | |
| Name of previous dentist: | Phone #: ( ) | |
| Date of last visit to dentist: | Services received: | |
| Please (circle) Yes or No to the following questions . | | |
| Has your child had any trouble associated with any previous dental treatment? Y N<br>Have you been satisfied with your child's previous dental care? Y N<br>Does child brush daily? Y N<br>Does child floss daily? Y N | Do gums bleed while brushing or flossing? Y N<br>Bite lips, cheeks, or nails? Y N<br>Sensitivity to hot/cold, sweet/sour? Y N<br>Is fluoride taken in any form? Y N | Does child suck his/her thumb? Y N<br>Does child use a pacifier or bottle? Y N<br>Had orthodontic work? Y N<br>Experience pain in any teeth? Y N |

The information that I have given is correct to the best of my knowledge. I understand that it will be held the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also understand the use of anesthetic agents embodies a certain risk. I authorize the dental staff to perform the necessary dental services for my child. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that responsibility for payment for dental services provided in this office for my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any changes in my child's insurance coverage.

SIGNATURE _____ DATE _____

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Doctor Reviewed _____
Date _____