HEALTH HISTORY

Patient's Name_____ Date_____

Referred By_____

Dental History

Dentist's Name_____

Date of last dental visit?_____

What service was performed?_____

Has the child ever had a serious/difficult problem associated with previous dental work?___Y___N

Does the child brush their teeth daily?___Y___N

Child's attitude toward dentistry?_____

Any unhappy dental experiences?_____

Any injuries to the head, teeth or mouth?_____

Any unusual speech habits?_____

Has the child ever had any pain/tenderness in their jaw joint?___Y___N

Does the child have any of the following habits:

Thumb/finger sucking____ Nail biting____

Lip sucking/biting____ Mouth breathing____

Medical History

Physician's Name_____

Phone #_____ Date of last visit?_____

Is the child currently under the care of a physician?___Y___N

Please describe the child's current physical health: ____Good ____Fair ____Poor

Does the child have any specific allergies?_____

Please list all drugs that the child is currently taking:_____

_____

Please list all drugs that the child is allergic to:_____

_____

PLEASE COMPLETE THE OTHER SIDE

Has the child ever had any of the following medical problems?

Y	N	Anemia	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+/AIDS
Y	N	Bladder	Y	N	Kidney
Y	N	Cancer	Y	N	Liver
Y	N	Cerebral Palsy	Y	N	Mastoid
Y	N	Chicken Pox	Y	N	Measles
Y	N	Chronic Sinus	Y	N	Mumps
Y	N	Convulsions	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Rheumatic Fever
Y	N	Epilepsy	Y	N	Thyroid
Y	N	Fainting	Y	N	Tuberculosis
Y	N	Hearing	Y	N	Venereal Disease
Y	N	Heart Murmur	Y	N	Any Operations
Y	N	Heart (of any kind)	Y	N	Any stays in hospital
Y	N	Fever of unknown origin	Y	N	Night sweats
Y	N	Unexplained weight loss	Y	N	Bloody cough
Y	N	Prolonged cough (3-4 weeks)			

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of:_____
_____
_____

May we request a release of the Patient's medical records?____Y____N

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this 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.

_____

Signature of Parent or Guardian Date
(If parents are divorced, only the custodial parent may sign consent to treat)

In order to file your insurance, the following section must be completed by an authorized party.

I hereby authorize release of any information relating to this claim.

Signature_____ Date_____

I hereby authorize payment of insurance benefits directly to the dentist.

Signature_____ Date_____