# CHILD PATIENT HISTORY

Date _____

Child's Name _____ Sex [ ] M [ ] F Date of Birth_____/_____/_____(mm/dd/yyyy)

Street Address _____ Home phone _____-_____-_____

City _____ State _____ Zip Code _____

Father _____ Cell phone _____-_____-_____

Email address _____ Work phone _____-_____-_____

Mother _____ Cell phone _____-_____-_____

Email address _____ Work phone _____-_____-_____

How did you hear about our office: [ ] Referred [ ] Insurance Company [ ] Website [ ] Other _____

**MEDICAL HISTORY:**

Physician's Name _____ Phone _____-_____-_____

Date of last physical _____ Results: [ ] Excellent [ ] Fair [ ] Poor

Is child being treated for any medical condition? YES NO Does child bleed excessively for a cut or extraction? YES NO

Is child required to take antibiotic premedication before dental treatment? YES NO Has child ever been hospitalized? YES NO

If yes, explain: _____

**List** all medications child is currently taking:

_____

_____

_____

_____

_____

**ALLERGIES:** [ ] **NONE**

[ ] Aspirin [ ] Nuts _____

[ ] Codeine [ ] Metals

[ ] Latex [ ] Local Anesthetic

[ ] Food Dyes [ ] Penicillin / Antibiotics

[ ] Sulfa [ ] Other_____

**Circle Y** for **YES** or **N** for **NO** if your child has ever had / has any of the following:

**Y N** ADD / ADHD
**Y N** AIDS / HIV Positive
**Y N** Anemia
**Y N** Artificial Bones / Joints
**Y N** Asperger Syndrome
**Y N** Asthma
**Y N** Autism
**Y N** Bleeding Problems
**Y N** Brain Injury
**Y N** Bruising Problems
**Y N** Cancer
**Y N** Cerebral Palsy
**Y N** Congenital Heart Defect
**Y N** Diabetes
**Y N** Eye Problems
**Y N** Fainting
**Y N** Febrile Seizures
**Y N** Hearing Loss
**Y N** Heart Murmur
**Y N** Hemophilia
**Y N** Hepatitis / Liver Problems
**Y N** Kidney Disease
**Y N** Learning Problems
**Y N** Mental Retardation
**Y N** Mononucleosis
**Y N** Physical Disability
**Y N** Pregnancy
**Y N** Psychiatric Disorder
**Y N** Rheumatic Fever
**Y N** Sickle Cell Disease / Trait
**Y N** Seizures / Epilepsy
**Y N** Transfusion
**Y N** Tuberculosis (TB)
**Y N** Yellow Jaundice

**Has your child ever had any illness or medical condition not listed…….. YES NO**

**If yes, explain** _____

**DENTAL HISTORY**

Reason for visit: [ ] Consult / Examination [ ] Pain [ ] New Patient

Last dental visit: [ ] First visit date of last visit _____

**Circle Y** for **YES** or **N** for **NO** if your child does or has done any of the following:

**Y N** Finger / Thumb Sucking **Y N** Nail biting **Y N** Pacifier **Y N** Nursing / Bottle

**Y N** Well water **Y N** Fluoride Supplements **Y N** Injuries to mouth / teeth / head

**Y N** Unhappy dental experience **Y N** Current dental issues / problems

Has the child ever had a serious / difficult problem associated with previous dental treatment? **YES NO**

**If yes, explain** _____

**INSURANCE INFORMATION:**

Insurance Co. Name _____ Phone _____-_____-_____ Group#(Plan, Local or Policy#) _____

Insurance Co. Address _____

Subscriber's Name _____ Relationship to patient _____

Subscriber's Birthdate _____/_____/_____ (mm/dd/yyyy) SSN/ID# _____

Subscriber's Employer _____ Work phone _____-_____-_____

**I understand that my dental insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for balance not covered by my insurance. I authorize the use of my signature on all of my insurance submissions, whether manual or electronic.**

_____

Parent / Guardian Signature