PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

PATIENT NAME _____ PREFFERED NAME _____ DATE _____

AGE _____ DATE OF BIRTH _____ SEX _____ RACE _____ SCHOOL _____ GRADE _____

ADDRESS _____
NUMBER AND STREET CITY STATE ZIP

TELEPHONE _____ EMAIL _____

PATIENT LIVES WITH: ☐ MOTHER ☐ FATHER ☐ OTHER _____

BROTHER (S) _____ SISTER (S) _____

NAME OF CHILD'S PHYSICIAN _____ DATE LAST SEEN _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATIONSHIP TO PATIENT _____ TELEPHONE _____

AUTHORIZATION AND FINANCIAL RESPONSIBILITY (please fill out completely)

PERSON RESPONSIBLE FOR CHILD'S FINANCIAL SUPPORT _____

ADDRESS _____ TELEPHONE _____

MOTHER'S NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

ADDRESS _____ TELEPHONE _____
HOME WORK CELL

EMPLOYER _____ ADDRESS _____

FATHER'S NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

ADDRESS _____ TELEPHONE _____
HOME WORK CELL

EMPLOYER _____ ADDRESS _____

IS YOUR CHILD COVERED BY A DENTAL INSURANCE PLAN? ☐ YES ☐ NO

PRIMARY INS. _____ SUBSCRIBER _____ ID# _____

SECONDARY INS. _____ SUBSCRIBER _____ ID# _____

HISTORY

		YES	NO	COMMENTS
1.	IS YOUR CHILD BEING TREATED BY A PHYSICIAN AT THIS TIME? IF YES, WHY? _____	☐	☐	
2.	HAS YOUR CHILD EVER BEEN A PATIENT IN A HOSPITAL? IF YES, WHY? _____	☐	☐	
3.	HAS YOUR CHILD EVER RECEIVED GENERAL ANESTHESIA OR SEDATION? IF YES, WHEN? _____	☐	☐	
4.	IS YOUR CHILD ALLERGIC TO ANYTHING? (MEDICINE, FOOD, ETC.) IF YES, WHAT? _____	☐	☐	
5.	IS YOUR CHILD TAKING ANY MEDICATIONS AT THIS TIME? IF YES, WHAT? _____	☐	☐	
6.	HAS YOUR CHILD EVER HAD A BLOOD TRANSFUSION?	☐	☐	
7.	DOES YOUR CHILD SMOKE OR USE TOBACCO PRODUCTS?	☐	☐	
8.	HAS YOUR CHILD EVER BEEN SEEN BY A DENTIST BEFORE? DATE LAST SEEN? _____ NAME OF DENTIST _____	☐	☐	
9.	HAS YOUR CHILD EVER RECEIVED FLUORIDE IN ANY FORM? IF YES, WHAT? _____	☐	☐	
10.	DOES YOUR CHILD SUCK HIS/HER THUMB, FINGERS, PACIFIER?	☐	☐	
11.	ARE YOUR CHILD'S TEETH BRUSHED ONCE OR MORE A DAY?	☐	☐	
12.	WHAT TYPE OF TOOTHPASTE DOES YOUR CHILD USE? _____			
13.	WHAT AGE DID YOUR CHILD STOP BOTTLE/BREAST FEEDING? _____			
14.	HAS YOUR CHILD EVER HAD DENTAL RADIOGRAPHS (X-RAYS) TAKEN? IF YES, WHEN? _____	☐	☐	
15.	REASON FOR BRINGING CHILD TO THE DENTIST _____			

WHOM MAY WE THANK FOR REFERRING YOU: NAME _____

ADDRESS & PHONE _____