HEALTH HISTORY

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Child's Name ___________________________________
Date of Birth __________________________________
Today's Date ___________________________________

Dental History

How often does your child brush? _________________________________
How often does your child floss? __________________________________
Is this your child's first visit to the dentist? __________________________
Date of last dental visit ____
Previous dentist ____
Has your child had any difficulty with previous visits? □ yes □ no
Comments ____
Child's physician ____
Address ____
Phone number ____

Is your child's water fluoridated? □ yes □ no □ don't know
Does your child take fluoride supplements? □ yes □ no □ don't know
Does your child have any of the following habits?
Suck thumb/finger □ yes □ no
Suck/bite lip □ yes □ no
Bite/chew nails □ yes □ no
Pacifier □ yes □ no
Chew hard objects □ yes □ no
Grind teeth □ yes □ no
Clecnch jaw □ yes □ no

Medical History

Has your child ever had any of the following?

ADD/ADHD	□ yes	□ no	Diabetes	□ yes	□ no
Abnormal Bleeding	□ yes	□ no	Down Syndrome	□ yes	□ no
Allergies/Hay Fever	□ yes	□ no	Handicaps/Disabilities	□ yes	□ no
Asthma	□ yes	□ no	Heart Murmur		
Autism	□ yes	□ no	Type ______________________		
Cancer/Hepatitis	□ yes	□ no	Hemophilia/Bleeding Disorder	□ yes	□ no
Cerebral Palsy	□ yes	□ no	HIV/AIDS	□ yes	□ no
Congenital Heart Defect	□ yes	□ no	Rheumatic Fever	□ yes	□ no
Convulsions/Epilepsy	□ yes	□ no	Tuberculosis	□ yes	□ no
Sickle Cell Anemia or Trait	□ yes	□ no			

Has your child ever taken Fen-Phen/Redux? □ yes □ no

Persistent cough or throat clearing not associated with known illness? □ yes □ no
(Lasting more than three weeks)

Is your child taking any medications ? □ yes □ no
Please list ____

Is your child allergic to any foods or medications? □ yes □ no
Please list ____

Is your child allergic to latex? □ yes □ no

Is your child allergic to Local Anesthetic (Novocain) □ yes □ no

Please explain any medical problems your may have ______________________________
____

Is there any information about your child we should be aware of? __________________
____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other dental practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf of my dependents. I understand there is a twenty-five (25) dollar broken appointment fee per half hour my child is scheduled without twenty-four (24) hour notice. Chronic failed appointments will be subject to dismissal from our office.

Signature ______________________________________ Date ______________
(Parent or Guardian)

Reviewed with parent ______________________________ Date ______________