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CHILD HEALTH HISTORY FORM

Tell Us About Your Child

Today's Date _____

Child's Name _____
Last First MI

Child's Birthdate ____/____/_____ Child's Age _____
☐ Male ☐ Female

Child's Home Phone (_____)_____

Child's Home Address _____
Apt/Condo #

_____
City State Zip

Mother:_____

Driver's License#:_____

Birthdate: ___/___/_____ Age:_____

SSN or Insurance ID#:_____

Home Address_____

Single Married Divorced Widowed Separated

Home Phone # (_____)_____

Cell # (_____)_____

Work Phone # (_____)_____

Email Address: _____

Occupation_____

Employer:_____

Employer's Address_____

Father:_____

Driver's License#:_____

Birthdate: ___/___/_____ Age:_____

SSN or Insurance ID#:_____

Home Address_____

Single Married Divorced Widowed Separated

Home Phone # (_____)_____

Cell # (_____)_____

Work # (_____)_____

Email Address:_____

Occupation _____

Employer _____

Employer Address _____

Person Responsible for Account (if other than Mother or Father)

Name:_____

Employer:_____

Driver's License#:_____

Work Ph #: (_____)_____

Home Ph #: (_____)_____

Email address:_____

Relationship to child?_____

Billing Address_____

SSN or Insurance ID#:_____

Birthdate:_____

Primary Insurance: Dental Insurance ? Yes No

Name if Insured (employee)_____

Insurance Co. Name: _____

Address:_____

Phone #:(_____)_____

Group #, (Plan, Local of Policy #) _____

Secondary Insurance: Dental Insurance? Yes No

Name if Insured (employee)_____

Insurance Co. Name: _____

Address:_____

Phone # (_____)_____

Group #, (Plan, Local of Policy #) _____

(**Please Turn Page)**

CHILD'S HEALTH HISTORY (CONT.)

What is the primary reason for today's visit?

_____

Your child's current dental health: □ Good □ Fair □ Poor

Has your child experienced problems associated with previous dental work? □ Yes □ No

Is your child's water fluoridated? □ Yes □ No

Do you like his/her smile? □ Yes □ No

If not why? _____

Child's Physician: _____

Phone # (____)_____Date of Last Visit:_____

Is the child currently under the care of a physician? □ Yes □ No

Please describe your child's current physical health: □ Good □ Fair □ Poor

Please list all drugs that your child is currently taking:

_____

Please list all drugs that cause your child allergic reactions:_____

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	AIDS	Y	N	Hepatitis
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Any Hospital Stays	Y	N	Hives
Y	N	Any Operations	Y	N	HIV*
Y	N	Asthma	Y	N	Immunizations Current
Y	N	Cancer	Y	N	Kidney
Y	N	Chicken Pox	Y	N	Liver Problems
Y	N	Congenital Heart Defect	Y	N	Low Blood Pressure
Y	N	Convulsions	Y	N	Measles
Y	N	Diabetes	Y	N	Mononucleosis
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Exposed to HIV but Neg.	Y	N	Scarlet
Y	N	Handicaps/Disabilities	Y	N	Skin Rash
Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur			

Does the child have any of the following habits?

Y	N	Lip Sucking	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb/Finger Sucking
Y	N	Chewing on Objects	Y	N	Tongue/Cheek biting
Y	N	Mouth Breather	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Tongue Trusts

Please discuss any serious medical problems the child experienced: _____

_____

_____

Anything you would like to discuss with the Doctor in private? _____

_____

_____

_____

_____

I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need and agree to be responsible for any services rendered. This includes the responsibility of any co-payment and deductibles that insurance does not pay.

_____

Signature **Date**

Notes

_____

_____

_____

_____