CHILD'S INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE_______________

REFERRED BY_______________

CHILD'S NAME_______________ M ☐ F ☐ _______________ DATE OF BIRTH_______________

(NICKNAME IF ANY)

CHILD'S ADDRESS_______________ CHILD'S PHONE_______________

HOBBIES, SPORTS AND INTERESTS_______________

PERSON RESPONSIBLE FOR THIS ACCOUNT_______________ RESIDENCE PHONE_______________

MAILING ADDRESS_______________

STREET ADDRESS (*if different*)_______________

EMPLOYED BY_______________ BUSINESS PHONE_______________

BUSINESS ADDRESS_______________

DENTAL INSURANCE (*if any*)_______________ INSURED S.S. #_______________ INSURED'S D.O.B_______________

DENTAL HISTORY

CHIEF ORAL COMPLAINT_______________

DATE OF LAST DENTAL EXAM_______________ ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE ☐ YES ☐ NO

EXPLAIN_______________

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

☐ Traumatic injury to mouth or teeth
☐ Teeth sensitive to cold, heat, sweets or pressure
☐ Bleeding gums, How long_______________
☐ Food impaction
☐ Clenching or grinding of teeth
☐ Swelling or lumps in mouth
☐ Frequent blisters on lips or mouth
☐ Pain around ear

☐ Bad breath
☐ Complications from extractions
☐ Topical Fluoride Treatment
☐ Orthodontic treatment
☐ Mouth Breathing
☐ Oral habits; thumbsucking, fingernail biting, cheek biting, etc.

☐ Texture of toothbrush_______________
☐ Frequency of brushing_______________
☐ Dental Floss
☐ Fluoride supplements
☐ Between meal snacks
☐ Well balanced diet

MEDICAL HISTORY

PHYSICIAN'S NAME_______________ DATE OF LAST VISIT _______________ PHYSICIAN'S PHONE_______________

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

☐ Allergy to Penicillin
☐ Allergy to other drugs
☐ Allergies to anesthetics
☐ Any heart ailments
☐ Radiation Treatments
☐ Excessive bleeding from cut or extractions
☐ Anemias or blood problems (hemophilia)
☐ Asthma
☐ Epilepsy or Seizures
☐ Heart Murmur

☐ hay Fever or allergies in general
☐ Diabetes
☐ Kidney problems
☐ Liver problems or hepatitis
☐ Malignancies or Leukemia
☐ Psychiatric care/emotional problems
☐ Rheumatic fever
☐ Mumps, Measles, German Measles
☐ Chicken Pox
☐ AIDS

☐ Sinus problems
☐ Physical or mental handicap
☐ Thyroid Disorders
☐ Eye Disorders
☐ Tonsillitis
☐ Ulcer or Colitis
☐ Extreme nervousness or apprehension
☐ Herpes or Cold Sores
☐ Allergy to Latex
☐ Other_______________

Describe any current medical treatment including drugs taken, even though not listed above_______________

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ADDITIONAL COMMENTS: _______________

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IN CASE OF EMERGENCY CALL: _______________

Name Relationship Phone

Address:_______________

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SIGNATURE_______________ DATE_______________