# HEALTH & DENTAL HISTORY – CHILD

OOSTBURG FAMILY DENTISTRY
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Today's Date:

## PATIENT INFORMATION

| Child's Last Name: | First: | Middle: |
|---|---|---|
| Date of Birth: | Age: | Sex: ❒ M ❒ F |

## HEALTH HISTORY

Is child generally in good health? **Yes** **No**

Is child taking any medications? **Yes** **No**

Is child under a physician's care? **Yes** **No** *Reason:*

Date and purpose of child's last physical exam:

Name of child's physician: City:

**Please check all that your child has had:**

| | | |
|---|---|---|
| ❒ chronic fainting/dizziness | ❒ asthma | ❒ reaction to dental anesthetic |
| ❒ excessive bleeding | ❒ heart trouble | ❒ latex allergy |
| ❒ blood transfusion | ❒ rheumatic fever | ❒ allergy to penicillin |
| ❒ diabetes | ❒ kidney infection | ❒ other drug allergy/reaction_____ |

**What else should we know about your child's health?**

## DENTAL HISTORY

Purpose of today's visit:

Date and purpose of child's last dental visit:

Name of child's previous dentist: City:

Has child had dental x-rays in the last 12 months? **Yes** **No**

Does child have any dental problems? **Yes** **No**

Does he/she eat a well-balanced diet? **Yes** **No**

Does he/she drink fluoridated water? **Yes** **No**

Does child brush his/her own teeth? **Yes** **No**

How often are child's teeth brushed?

Has child had any negative dental experiences? **Yes** **No**

Do you have any questions or concerns?

**Please check all that your child has had:**

❒ dental cavities ❒ dental anesthetic ❒ tooth extraction ❒ fluoride treatment
❒ orthodontic treatment/recommendation ❒ dental injuries: *Explain:*

## AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance. I authorize Oostburg Family Dentistry and my insurance company to release any information required to process my claims.

_____ _____

Parent or Guardian Signature Date

*revised July 2023*