Child Dental and Health History

First Name:______________________________ Last Name:___________________________
Reason for visit:___________________________ Former Dentist:______________________
Date of last dental x-rays:__________________ (If Applicable) Would you like your child to receive Fluoride: YES NO
Your child's overall health as well as any medications which your child takes have an important interrelationship with dental care your child receives. Please answer each of the following questions completely.

How often does your child brush?_________________
How often does your child floss?__________________
Is your water fluoridated?________________________
Does your child take fluoride supplements?__________
Previous Dentist_________________________________
Address____
Has your child had difficulty with a previous dentist___

Does your child

Suck thumb/finger	YES NO
Suck/Bite lip	YES NO
Bite/Chew nails	YES NO
Chew Hard Objects	YES NO
Grind teeth	YES NO
Clench jaw	YES NO

Child Physician __________________ Address_______________________________________
Office phone____________________ Date of last exam_______________________________
Previous Hospitalizations/Surgeries/Serious Illness___________________________________
____
Is your child taking any medications? YES NO   If yes, please list:
____
Has your child ever taken Fen-Phen/Redux? YES NO
Does your child have a history of allergies/sensitivities/adverse reaction to any drugs or medications? (Penicillin, Novocaine, etc) If yes, please describe: ____
Does your child have a history of allergies to other substances (latex, environmental, etc)?
____
Has your child had any of the following?

___Asthma	___Abnormal bleeding	___Cancer	__Hepatitis
___AIDS/HIV	___Thyroid problem	___Hemophilia	__Kidney problems
___Tuberculosis	___Diabetes	___Rheumatic Fever	___Fainting/Seizures
___Congenital Heart Defect	___Stomach, liver or Kidney problems		___Heart murmur
___Epilepsy/Convulsions	___Persistent cough or throat clearing not associated with a known illness lasting longer that three weeks		

Please explain any medical problems your child has: ____
____

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 also authorize the dental staff to perform to perform the necessary dental services my child may need.

I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____ Date: ______________________________
Signature of patient (or Parent/Guardian to minor (Todays Date)

____ Date: ______________________________
Signature of Dentist (Todays Date)