Child Health Record

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

Medical History

Is your child having pain or discomfort at this time? ..... Yes ☐ No ☐
Does your child feel very nervous about having dental treatment? ..... Yes ☐ No ☐
Has your child ever had a bad experience in any dental office? ..... Yes ☐ No ☐
Has your child been a patient in the hospital during the past 2 years? ..... Yes ☐ No ☐
Has your child been under the care of a medical doctor during the past 2 years? ..... Yes ☐ No ☐
Has your child taken any medicine or drugs during the past year? ..... Yes ☐ No ☐
Is your child allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications including local anesthetics? ..... Yes ☐ No ☐
Has your child ever had any excessive bleeding requiring special treatment? ..... Yes ☐ No ☐
Has your child had a physical exam within the past year? ..... Yes ☐ No ☐
List all the medications your child is taking at the present time: _____

_____

_____

Circle any of the following which your child has or has had in the past:

High blood pressure	Kidney trouble	Hay fever	Chronic sinus	Thumb sucking
Low blood pressure	Asthma	Cerebral palsy	Allergies or hives	Nail biting
Pain in region of ears	Arthritis	Measles	Bleeding gums	Diabetes
Tuberculosis (TB)	Tonsilitis	Liver disease	Yellow jaundice	Chemotherapy (cancer, leukemia)
Hepatitis A (infectious)	Hepatitis B (serum)	Cold sores	Chicken pox	AIDS
Hemophilia	Venereal Disease	Fainting or dizzy spells	Nervousness	Food collect between teeth
Bruise easily	Tongue thrusting	Rheumatic Fever	Mouth breathing	Blood transfusion
Mastoid/ear infection	Congenital heart lesions	Artificial heart valve	Scarlet fever	Epilepsy or seizures
Heart murmur	Heart surgery	Mumps	Anemia	Sickle cell disease
HIV				

Is this the child's first dental visit? ..... Yes ☐ No ☐

If there was a previous dental experience:
Was it satisfactory? ..... Yes ☐ No ☐
Was a local anesthetic given? ..... Yes ☐ No ☐
Were x-rays taken? ..... Yes ☐ No ☐
Were home care instructions given? ..... Yes ☐ No ☐
Were regular preventive visits made? ..... Yes ☐ No ☐
Was there a history of dental decay? ..... Yes ☐ No ☐
Were there any special problems? ..... Yes ☐ No ☐

Please add anything you feel is important: _____

_____

_____

Date _____

Permission hereby granted to the doctor to perform any necessary dental work for this child:

Signature of parent or guardian: _____

OVER

Personal Information

Today's Date _____

Child's name _____ Home phone _____

Date of birth _____ Age _____ Home address _____

City _____ Zip _____ Referred by _____

Mother's name _____

Mother's occupation _____ Employer _____

Mother's work phone _____ Years with firm _____

Father's name _____

Father's occupation _____ Employer _____

Father's work phone _____ Years with firm _____

Parent's marital status _____

Person financially responsible _____ Relationship to child _____

Your child's physician _____ Phone or address _____

Your child's former dentist _____ Address _____

Date of your child's last dental visit _____

Person to contact in case of emergency: _____ Phone _____

Parent ☐ relative ☐ friend ☐

Primary dental insurance coverage

Name of Insured: _____ Birthdate _____

Ins. Co. _____ Group #: _____

Soc. Sec. #: _____

Place of employment: _____

Secondary dental insurance coverage

Name of Insured: _____ Birthdate _____

Ins. Co. _____ Group #: _____

Soc. Sec. #: _____

Place of employment: _____

Signature _____