Child Health History Form

ABOUT YOUR CHILD

Child's Full Name:

First Name: _____ Last Name: _____

Birth Date (MM/DD/YYYY): _____ **Sex** (M/F): _____

Age: _____

Reason for visit: _____

_____

_____

Referred To This Office By:

Full Name: _____

Phone Number: _____

DENTAL HISTORY

Is this your child's first dental visit? Yes No

Any injuries to the teeth or jaws? Yes No **If Yes, when:** _____

Does Your Child Receive: ☐ Flouride in Vitamins ☐ Flouridated Water ☐ Gummy Vitamins
☐ Flouride Tabs/Drops ☐ None

Has your child experienced any unfavorable reaction from previous medical or dental care? Yes No

If yes, explain: _____

How do you think your child will act towards the dentist? _____

_____

_____

_____

MEDICAL HISTORY

Child's Physician/Pediatrician's Name: _____

Physician Phone Number: _____

Is your child presently under the care of a specialist for any medical reason? Yes No

Does your child have a history of health problems? Yes No

If yes, what: _____

Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt or other medical reason? Yes No

If yes, what: _____

Is your child presently taking any medications? Yes No

If yes, what: _____

Has your child had a history of taking frequent medications? Yes No

If yes, explain: _____

Has your child been hospitalized or had surgery? Yes No

If yes, explain: _____

Is your child allergic to any drugs? Yes No

If yes, what: _____

Is your child allergic to any foods? Yes No

If yes, what: _____

Is your child allergic to any medications or dyes? Yes No

If yes, what: _____

Is your child allergic to any environmental pollutants? Yes No

If yes, what: _____

Is your child allergic to any latex, metals, or acrylics? Yes No

If yes, what: _____

Has any family member, including your child had a problem with general anesthetic? Yes No

If yes, explain: _____

Has your child ever been diagnosed as having any of the following conditions?

ADD/ADHD? Yes No **AIDS/HIV?** Yes No **Anemia?** Yes No **Arthritis?** Yes No

Asthma? Yes No **Autism?** Yes No **Birth Defects?** Yes No **Brain Injury?** Yes No

Bladder Conditions? Yes No **Blood Disease?** Yes No **Blood Transfusions?** Yes No

Bone or Joint Problems? Yes No **Bruising Easily?** Yes No **Cancer or Malignancies?** Yes No

Cerebral palsy? Yes No **Chemotherapy/Radiation?** Yes No **Child Abuse?** Yes No

Chronic Adenoid/Tonsil Infections? Yes No **Chronic Ear Infections?** Yes No

Cleft Lip/Palate? Yes No **Congenital Heart Lesion?** Yes No **Convulsions/Seizures?** Yes No

Developmentally Delayed? Yes No **Diabetes?** Yes No **Drug Addiction?** Yes No

Ear Stuffiness, Itching, or Noises? Yes No **Emotional Disturbance?** Yes No

Epilepsy? Yes No **Eye Problems?** Yes No **Excessive Bleeding Problem?** Yes No

Excessive Gagging? Yes No **Fainting or Dizziness?** Yes No **Fever Blisters?** Yes No

Growth/Developmental Problems? Yes No **Heart Surgery?** Yes No **Headaches?** Yes No

Hearing/Speech Impairments? Yes No **Heart Murmur/Defects?** Yes No

Hemophilia? Yes No **Hepatitis/Liver Disease?** Yes No **High Blood Pressure?** Yes No

Kidney Disease? Yes No **Leukemia?** Yes No **Mental Disability?** Yes No

Mouth Sores? Yes No **Nutritional Deficiency?** Yes No **Orthopedic Problems?** Yes No

Pain in Jaw Joints? Yes No **Premature Birth?** Yes No **Psychiatric Care?** Yes No

Rheumatic Fever? Yes No **Scoliosis?** Yes No **Sickle Cell Anemia?** Yes No

Tuberculosis? Yes No **Syndrome?** Yes No

Other? Yes No **If yes, explain:** _____

Do you wish to talk to the doctor privately about a special concern? _____

_____

RESPONSIBLE PARTY (PARENT/GUARDIAN)

Parent/Guardian Full Name:

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____ **Social Security:** _____

Address:

Street Address: _____

Street Address Line 2: _____

City: _____ State/Province: _____ Postal/Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Business Phone: _____ **Email:** _____

Employer: _____ **Occupation:** _____

Parent/Guardian Full Name:

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____ **Social Security:** _____

Address:

Street Address: _____

Street Address Line 2: _____

City: _____ State/Province: _____ Postal/Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Business Phone: _____ **Email:** _____

Employer: _____ **Occupation:** _____

Is patient living with both parents/guardians? Yes No

Siblings:

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: _____ **Group No. :** _____

Insurance ID Number: _____ **Policy Holder Name:** _____

Secondary Dental Insurance: _____ **Group No. :** _____

Insurance ID Number: _____ **Policy Holder Name:** _____

CONSENT FOR TREATMENT

☐ **I am the (parent/guardian) of the child listed above who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Growing Smiles. This includes exposure of radiographs as necessary, use of local anesthesia, inhalation and oral medication, responsible restraint as needed, and use of appropriate medicaments and materials for such treatment. If I have any objections to certain aspects of treatment. I have stated so in the space provided below. I will assume responsibility for fees associated with those procedures for my child.**

Signature of Parent/Guardian: _____

Date: _____