THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name _____ **Preferred Name** _____ **Age** _____

Sex _____ **Race** _____ **Date of Birth** _____ **Place of Birth**_____ **Patients Social Security #** _____-_____-_____

Patient's Address _____ **Home Phone** _____
Street City State Zip

Father's Name _____ **Social Security #** _____-_____-_____
Date of Birth

His Address _____ **Phone** _____
Street City State Zip

Where Employed _____ **Phone** _____

Fathers Dental Insurance _____

Mother's Name _____ **Social Security #** _____-_____-_____
Date of Birth

Her Address _____ **Phone** _____
Street City State Zip

Where Employed _____ **Phone** _____

Mother's Dental Insurance _____

With whom does patient live? _____ **E-mail Address**_____

Other Children in family – names and ages _____

Child's Physician _____ **Family Dentist** _____

Whom may we thank for referring you to our office? [] Doctor [] Parent [] Patient _____

HEALTH HISTORY

	Yes	No
Child's weight _____		
Is your child in good health?	___	___
Is your child up to date with immunizations?	___	___
Is your child presently taking medicine?	___	___
If so, what? _____		
Has your child experienced any unfavorable reaction to medicine?	___	___
If so, what? _____		
Is your child presently undergoing medical treatment?	___	___
If so, what? _____		
Has your child been hospitalized since birth?	___	___
Date _____ Reason _____		
Does your child have any infectious diseases?	___	___
If yes, what? _____		

	Yes	No
Has your child experienced chronic cough?	___	___
night sweats?	___	___
chronic fatigue?	___	___
recurrent mouth sores?	___	___
Has your child ever had blood transfusions?	___	___
chemotherapy?	___	___
transplant surgery?	___	___

Check any of the following that may pertain to your child

___ Heart condition	___ Lung
___ Tuberculosis	___ Asthma
___ Brain Injury	___ Allergies
___ Liver Problem	___ Retardation
___ Kidney Problem	___ Diabetes
___ Mental Disorders	___ Epilepsy
___ Emotional Disorder	___Hepatitis
___ Nervous Disorder	___Autism
___ Sickle cell anemia	___ Speech
___ Cerebral palsy	___ Hearing
___ Bleeding Disorder	___ Vision
___ Other _____	

What is your water source? [] Private well [] Public system Name of system: _____

	Yes	No
Is this your child's first dental visit?	___	___
If not date of last dental care? _____		
Has your child had an unfavorable Experience in a dental office?	___	___
Does your child have a toothache?	___	___
Purpose of appointment_____		

	Yes	No
Is your child a finger sucker?	___	___
Does your child use a pacifier?	___	___
Was your child bottle-fed?	___	___
Age discontinued? _____		
Was your child breast-fed?	___	___
Age discontinued? _____		

Thank you for your help. If there is any information that you think may be of value to us in treating your child, please feel free to comment _____

_____