Health History Form

Parent/Legal Guardian's Email Address

Today's Date

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PATIENT INFORMATION

First Name

Last Name

MI

Preferred Name

Gender

Date of Birth

Previous Visit

CONTACT INFORMATION

Home Phone

Cell Phone

Work Phone

Preferred Method of Contact

- [ ] Phone
- [ ] Text
- [ ] Email

Mailing Address

City

State

Zip

Parent/Legal Guardian's Name(s)

Pediatrician's Name

Pediatrician's Phone Number

HEALTH HISTORY

Does your child have any medical condition or disabilities?....... Yes ☐ No ☐

If yes, please list

Have you ever been told your child needs antibiotics before a dental visit?.. Yes ☐ No ☐

Has your child ever had heart or cardiac problems?.................. Yes ☐ No ☐

Has your child had any surgeries or hospital visits?................... Yes ☐ No ☐

If yes, please list

Does your child take any medications on a daily basis?............ Yes ☐ No ☐

If yes, please list

Does your child have any food or medication allergies?............ Yes ☐ No ☐

If yes, please list

Is your child allergic to latex, pine nuts or dairy products?......... Yes ☐ No ☐

If yes, please list

Does your child have asthma or reactive airway disease?.......... Yes ☐ No ☐

What asthma medications were used last and when?

Please select all conditions your child currently has, or HAS HAD in the past.

- ☐ Heart Murmur
- ☐ Cleft lip/palate
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Seizures
- ☐ Hearing/Visually Impaired
- ☐ Rheumatic fever
- ☐ Diabetes
- ☐ Developmental Delay/CP
- ☐ Eczema
- ☐ HIV/AIDS
- ☐ Ports/Catheters
- ☐ Anemia/Sickle Cell
- ☐ Ear Problems
- ☐ Autism/PDD
- ☐ Liver/Kidney disorders
- ☐ ADD/ADHD
- ☐ Cancer
- ☐ None

Does your child have any physical or mental disabilities or speech problems?.. Yes ☐ No ☐

If yes, please explain

DENTAL HISTORY

What is the reason for your visit?

Is this your child's first visit to the dentist?

- [ ] Yes
- [ ] No

How do you think your child will do at this visit?

- [ ] Good
- [ ] Apprehensive
- [ ] Uncooperative

Has your child ever had a negative dental experience in the past?

- [ ] Yes
- [ ] No

Has your child had a toothache recently?

- [ ] Yes
- [ ] No

If yes, please describe

Does your child have any of the following habits?

- [ ] Finger Sucking
- [ ] Pacifier
- [ ] Teeth Grinding
- [ ] None

What type of water does your child drink?

- [ ] Tap
- [ ] Fridge
- [ ] Bottle
- [ ] Brita
- [ ] Pur
- [ ] Other

Has your child ever had any injuries to the jaw, head, mouth, or teeth?

- [ ] Yes
- [ ] No

If yes, please describe

Is there anything else about your child that you think we should know in order to better treat their dental needs?

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

- [ ] I acknowledge that the above information is correct and grant permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete their treatment. If there is a change in my child's health, allergy or medication history, I will inform the dentist & staff immediately prior to any future appointments.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date

All parties involved agree that this document may be signed electronically. The electronic signatures appearing on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.