Child Health/Dental History Form

ADA American Dental Association®

America's leading advocate for oral health

							5.11	
Patient's Name	FIF	ST INITIAL	Nickname		Date of Birth			
Parent's/Guardian's Name	Relationship to Patient							
Address								
PO OR MAILING AD	DRESS		CITY		STATE	ZIP CODE		1
Phone		Work			Sex M□ F	ч		
Have you (the parent/gua 1. Active Tuberculosis,	2. Persistent cough grea	any of the following diseases ter than a three-week duration	n, 3.Cough that produce	es blood?		🗅 Yes	□ N	lo
		ove, please stop and return		onist.				
Has the child had any l	history of, or condition Cancer	s related to, any of the followard Epilepsy	owing: HIV +/AIDS	□ Mono	nucleosis	☐ Thyroid		
☐ Arthritis	☐ Cerebral Palsy ☐ Fainting		☐ Immunizations ☐ Mumps			☐ Tobacco/Drug Use		
□ Asthma	☐ Chicken Pox ☐ Growth Problems		☐ Kidney		ancy (teens)	☐ Tuberculosis	, 000	
□ Bladder					matic fever	☐ Venereal Dise	926	
☐ Bleeding disorders			☐ Latex allergy☐ Liver☐	□ Seizur			asc	
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	□ Sickle		Other		-
			u ivieasies	U SICKIE	Cell			
Please list the name an	a phone number of the	child's physician:						
Name of Physician		*			_Phone			_
Child's History							Yes	No
		er the counter medications	or vitamin supplements a	at this time?.				
If yes, please list:								
		certain foods? If yes, please						
4. How would you desc	cribe the child's eating h	abits?						
5. Has the child ever ha	ad a serious illness? If y	es, when: Pl	ease describe:			5.		
6. Has the child ever been hospitalized?								
7. Does the child have a history of any other illnesses? If yes, please list:								
Has the child ever received a general anesthetic? Does the child have any inherited problems?								
Does the child have any speech difficulties?								
11. Has the child ever had a blood transfusion?								
12. Is the child physically, mentally, or emotionally impaired?						11.	ш	
13. Does the child experience excessive bleeding when cut?						12.		
14. Is the child currently being treated for any illnesses?						13.	u	
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date.						14.	ш	
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date:								
16. Has the child had any problem with dental treatment in the past?								
17. Has the child ever had dental radiographs (x-rays) exposed?						17.		
18. Has the child ever suffered any injuries to the mouth, head or teeth?								
19. Has the child had any problems with the eruption or shedding of teeth?								
20. Has the child had any orthodontic treatment? 21. What type of water does your child drink? City water Well water Bottled water Filtered water								
		s?				200		
		or						
		d per day? Who						
25. Does the shild suck	his/hor thumb fingers of	r pacifier?	en are the teeth brushed			24.	0	
		? Age Breast					_	
27. Does child participat	e in active recreational a	ctivities?	g: Age			27.		
NOTE: Both doctor and I certify that I have read an	patient are encourage and understand the above my dentist, or any othe	to discuss any and all rele e. I acknowledge that my que member of his/her staff, res	evant patient health iss estions, if any, about inqu	ues prior to iries set forth	treatment. above have be	een answered to m		
Parent's/Guardian's Signat	ure			Date				
For completion by dent	ist							
The state of the s								
							-	
ATTENDED TO SECONDARY								
-								
For Office Use Only - D Media	al Alast D Dramadiantian E	Allergies D Anesthesia Review	- 4 b.					