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HEALTH HISTORY

We believe that to best serve your child's dental health, we must understand your child in the larger context of his/her social and medical history. Please help us by thoughtfully answering the following questions. Please note that all health histories are held in strict confidence among our team. Complete both pages of the form.

_____ M / F
Child's Name (Last, First) Child's Nickname Date of Birth Weight

Child's Physician _____ Phone _____ Family Dentist _____
Physician's Address _____

Is the child under care for any medical conditions? (Y / N) Medical diagnosis? _____

Immunizations up to date? (Y / N / Unsure) Medication taken by child? _____

Has child ever spent the night in a hospital? Explain: _____

Allergies: Latex (Y / N) Metal (Y / N) Foods: _____
Medications: _____
Reaction to above allergies: _____

Has your child ever had or been diagnosed with any of the following:

- | | |
|--------------------------------------|--|
| (Y) (N) | (Y) (N) |
| ___ ___ Anemia | ___ ___ Aids/HIV |
| ___ ___ Blood Disease | ___ ___ Cancer or Malignancy |
| ___ ___ Blood Transfusions | ___ ___ Chronic Illness |
| ___ ___ Bruises Easily | ___ ___ Diabetes |
| ___ ___ Hemophilia | ___ ___ Epilepsy |
| ___ ___ Sickle Cell Trait or Disease | ___ ___ Hepatitis/Liver disease |
| | ___ ___ Kidney Disease |
| | ___ ___ Transplant _____ |
| (Y) (N) | (Y) (N) |
| ___ ___ Asthma | ___ ___ Birth Defects |
| ___ ___ Respiratory Problems | ___ ___ Child Abuse |
| ___ ___ Disease/RSV | ___ ___ Concussion |
| ___ ___ Heart Surgery | ___ ___ Growth Problems |
| ___ ___ Heart Murmur/Defect | ___ ___ Premature Birth |
| ___ ___ High Blood Pressure | ___ ___ Surgery _____ |
| ___ ___ Rheumatic Fever | ___ ___ Syndrome _____ |
| (Y) (N) | (Y) (N) |
| ___ ___ Arthritis | ___ ___ Brain Injury |
| ___ ___ Bone/Joint Problem TMJ | ___ ___ Developmental Delays |
| ___ ___ Headaches | ___ ___ Hearing and/or Speech Problems |
| ___ ___ Metabolic Disorder | ___ ___ Hyperactivity/ADD/ADHD |
| ___ ___ Muscle Disorder | ___ ___ Neurological Disorder |

Dentist's Notes

<p>HEALTH HISTORY REVIEWED</p> <ul style="list-style-type: none"> <input type="radio"/> No Concerns <input type="radio"/> Medical Alert <input type="radio"/> Allergy <input type="radio"/> _____ <input type="radio"/> PreMed <input type="radio"/> _____ <input type="radio"/> Call MD <input type="radio"/> _____ <p>Doctor's Initials _____</p>

Are there any other conditions we need to know? _____

Has your child ever had traumatic injury to the head? _____

Has your child ever had traumatic injury to the teeth? _____

Health History – Page 2

Please answer based upon your child’s age:

1. Feeding History (ages 0 – 2.5 years):
My child was: ___breast fed ___bottle fed ___combination
Bottle introduced at age: _____
Bottle Use: ___currently used ___discontinued (At what age? _____)

2. Oral Hygiene (ages 0 – 9 years):
Have you ever received instruction on how to clean your child’s teeth? ___yes, ___no
My child brushes _____times a day. An adult (___supervises, ___helps, ___brushes, ___none) per day.
My child has their teeth flossed (___ every day, ___occasionally, ___not currently).

3. Fluoride Use (all ages):
When did your child begin to use toothpaste? _____ How often / day? _____
Who applies the toothpaste to the brush? ___child, ___adult
My child (___does, ___did, ___did not) receive supplemental fluoride drops or tablets.
Our primary water supply (___does, ___does not, ___unsure) contain fluoride.

4. Habits (all ages):
My child (___does, ___ does not) suck a (___ thumb, ___ finger, ___pacifier).
When, where and how often? _____ Stopped at age: _____

5. Dental History (all ages):
Is there any history in your family of any:
___malocclusions (bad bites), ___missing teeth, ___extra teeth, ___other(explain _____)

Do you think there is anything wrong with your child’s teeth? _____
Has your child ever had a ___space maintainer, ___retainer, ___braces, ___ or any other orthodontic treatment? (Explain: _____)

What is the primary reason for today’s visit? _____

6. Family History (all ages):
Do mother and father live together? ___yes, ___no
Is your child adopted? ___yes, ___no If yes, when? _____
Please explain any recent family status changes (divorce, separation, death, etc.), and note when your child experienced this change: _____
Is your child receiving any therapy or extra help in any area? _____

7. Referral (all ages):
How did you hear about our office? (List name or media responsible for referral): _____

CONSENT

It is necessary, because your child is a minor, for permission to be obtained from a parent/legal guardian before necessary treatment is performed. The signature of the parent/guardian below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment, regardless of insurance coverage.

Also, the undersigned consents to the use of agreed upon x-rays, study models, photographs or any other diagnostic aids used for educational purposes. I fully understand this consent and have no further questions.

Signed: _____ Date: _____