

CONFIDENTIAL

Dental & Health History

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ How often does your child floss? _____
 Yes No Does your child take fluoride supplements? Yes No
Is your child's water fluoridated? _____
Does your child: Yes No Chew hard objects (pencils, etc.)..... Yes No
Suck thumb/finger..... Yes No Grind teeth..... Yes No
Suck/Bite lip..... Yes No Clench jaws?..... Yes No
Bite/Chew nails?..... Yes No
Previous dentist _____ Address _____
Date of last dental visit? _____
Has your child had difficulty with any previous dental visits? Yes No

Childs physician _____ Address _____
Phone # _____

Previous Hospitalizations/Surgeries/Serious Illness? _____ When? _____

Is your child taking any medications? Yes No (if yes, please list)

Has your child taken Fen-Phen/Redux? Yes No

Does your child have a history of allergies/sensitivies/adverse reaction to any drugs or medications (penicillin, Novocain, etc.)?
 Yes No (if yes, please describe)

Does your child have a history of allergies to any other substance (latex, environmental, etc.)?

Has your child every had any of the following:
Asthma..... Yes No Stomach, liver or kidney problems..... Yes No
Cancer..... Yes No Handicaps/Disabilities..... Yes No
Hepatitis..... Yes No Tuberculosis..... Yes No
HIV/AIDS..... Yes No Diabetes..... Yes No
Hemophilia..... Yes No Rheumatic Fever..... Yes No
Congenital Heart Defect..... Yes No
Heart Murmur..... Yes No
Convulsions/Epilepsy..... Yes No
A persistent cough or throat cleaning not associated with a known illness (lasting more than 3 weeks)?
Abnormal Bleeding..... Yes No

Please explain any medical problems that your child has: _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor _____
Dentist Review: _____

_____ Date

Signature of Dentist _____

_____ Date