

## CHILD HEALTH QUESTIONNAIRE

*In order to provide a complete dental exam for your child, please answer the following questions as completely as possible*

Child's Name \_\_\_\_\_ Child's Soc. Sec. No. \_\_\_\_\_

Birth date \_\_\_\_\_ Nickname \_\_\_\_\_ School Name \_\_\_\_\_ Grade \_\_\_\_\_

Favorite Pet or Toy \_\_\_\_\_ Pet's Name \_\_\_\_\_

Is Child Adopted? Yes  No  Legal Guardian's Name \_\_\_\_\_

Child's Physician \_\_\_\_\_ Date of last Physical Exam \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

How is your child's general health? \_\_\_\_\_

Has your child had any serious illness? Yes  No

If yes, describe: \_\_\_\_\_

Has your child ever been hospitalized? Yes  No

For what reason? \_\_\_\_\_

Is your child receiving any medication at this time? Yes  No

If yes, describe: \_\_\_\_\_

Has your child ever had an allergic reaction to the following:

Dental Anesthetics  Antibiotics  Food  Drugs  Latex

Please describe: \_\_\_\_\_

Has your child ever received a blow or injury to his head or teeth? Yes  No

Describe: \_\_\_\_\_

Has your child ever been treated with X-ray or radiation therapy? Yes  No

Has your child ever had any of the following conditions? Please check:

		Yes	No			Yes	No			Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	TB (tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	Age _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Aids or HIV	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Age _____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	Age _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	Age _____
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Age _____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Age _____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Age _____	Circle- Disease or Trait			

Other (please describe) \_\_\_\_\_

Does your child have any habits we should know about, such as:

Poor Eating Habits  Thumb Sucking  Pacifier  Bottles  Other \_\_\_\_\_

Does your child receive fluoride in: Drinking Water at Home Yes  No  By Prescription Yes  No

Do you have a home filtration system installed? Yes  No  Well water Yes  No

Has your child had any unpleasant dental experiences? Yes  No

How can we help? \_\_\_\_\_

Has your child ever had orthodontic treatment? Yes  No  When? \_\_\_\_\_

What is the nature of today's visit? Regular exam  Emergency  State Problem \_\_\_\_\_

Other  \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ DATE \_\_\_\_\_

Signature of Doctor/Staff \_\_\_\_\_

*Welcome and thank you for letting us care for your child's smile!*

### CHILD HEALTH HISTORY UPDATES

## WELCOME

We wish to thank you for placing your confidence in our office by allowing us to help you eliminate and control dental disease. In order for us to better serve you, please fill in the following information completely on both sides:

**Father's Name** \_\_\_\_\_ S.S.# \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status \_\_\_\_\_ Driver License # \_\_\_\_\_ Phone# \_\_\_\_\_

Employed by \_\_\_\_\_ Position \_\_\_\_\_ Years held \_\_\_\_\_

Address \_\_\_\_\_ Work # \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Group # \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ S.S.# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status \_\_\_\_\_ Driver License # \_\_\_\_\_ Phone # \_\_\_\_\_

Employed by \_\_\_\_\_ Position \_\_\_\_\_ Years held \_\_\_\_\_

Address \_\_\_\_\_ Work # \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name, address and phone of nearest relative not living with you \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

*For your benefit a thorough examination, usually including x-rays of your mouth, is necessary before intelligent and efficient analysis of your oral condition can be made. After thorough diagnosis, your dental problems can be discussed intelligently, treatment can be planned, and your investment in this health plan understood and arranged.*

*We like our patients to know what our office policy is with regard to insurance and extension of credit. Payment is due the day treatment is rendered. We will be happy to bill your insurance company for you at no charge. All charges are the patient's responsibility regardless of coverage. If special arrangements need to be made please talk with our front office staff. She will be happy to answer any of your questions concerning your insurance benefits, or your treatment charges.*

*I hereby authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the doctor, of insurance benefits under which I am entitled.*

**Legal Guardian, Please sign:** \_\_\_\_\_ **Date** \_\_\_\_\_