Child Health/ Dental History Form (Ages 3-9)

Childs Name ______________________________ Age _____ Birthdate _____________Parent/Guardian's Name ________________________________

Address ____City ___________________________ State ___________ Zip _____________________

Phone: Home _________________________ Cell: ___________________________ Work: ___________________________

Insurance Co ___________________________ Group Number _______________ ID Number _________________ Employer Name _________________

Employee Name ____________________________Employee Date of Birth ______________ Employee Social Security No. _________________________

Please check ALL of the following conditions that your child presently has or has had in the past

___ Heart condition
Date:________
Type:____________________

___ Diabetes: Type___________

___ Asthma, shortness of breath

___ Mental health concerns

___ ADHD
___ ADD
___ Autism

___ Cancer: Type:_________________
Date:______________
___ Radiation treatment
___ Chemotherapy
___ Dry mouth

___ Epilepsy/Seizures:
Type:____________________
Date of last episode:____________

___ Acid reflux, GERD
___ Anxiety
___ Depression
___ Snore
___ Headaches

YES NO Has the child had any allergies or adverse reactions? **LATEX PENICILLIN GLUTEN SULFA OTHER** ________________

YES NO Is this the child's first visit to a Dentist? If no: Date of last visit ___________________________

YES NO Has the child had any problem with dental treatment in the past? If yes, please explain ____

YES NO Has the child had any orthodontic treatment? If yes: Office name ____ Phone ______________________

YES NO Has the child ever suffered any injuries to the mouth, head, teeth? If yes, please explain ____

YES NO Does the child suck his/her thumb, fingers or pacifier?

YES NO Does the child have any conditions not listed **OR** any important information to share? ____

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List all medications your child is currently taking (Or attach a copy of his/her medication list) :

Drug ____________________________ Reason______________________ Drug ____________________________ Reason______________________

Drug ____________________________ Reason______________________ Drug ____________________________ Reason______________________

PATIENT/GUARDIAN SIGNATURE____ **DATE**________________________________

UPDATES

Date _______ Changes ____

Patient Signature ____ Staff ___________________

Date _______ Changes ____

Patient Signature ____ Staff ___________________

Date _______ Changes ____

Patient Signature ____ Staff ___________________