PRECISION DENTAL

DATE_____

PEDIATRIC HEALTH HISTORY

CHILD'S NAME _____ PREFERRED NAME _____ DATE OF BIRTH_____

FATHER'S NAME _____ MOTHER'S NAME_____

HOME PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

MAILING ADDRESS _____ CITY _____STATE _____ ZIP _____

SCHOOL_____ GRADE_____ FAVORITE HOBBY_____ FAVORITE SPORT_____

PREFERRED METHOD OF CONTACT: ❑ HOME ❑ WORK ❑ EMAIL ❑ CELL

BILLING & INSURANCE INFORMATION: ❑ NOT COVERED BY DENTAL INSURANCE DENTAL INSURANCE CO._____

POLICY HOLDER:_____ PARENT'S SOCIAL SECURITY NUMBER: _____ GROUP #: _____

HEALTH HISTORY

DENTAL HISTORY

DATE OF LAST DENTAL VISIT _____

FOR WHAT_____

SEEN BY DR. _____

ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS?

_____

HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS? _____

ANY INJURIES TO MOUTH, TEETH, HEAD? _____

ANY MOUTH HABITS: THUMB SUCKING, NAIL BITING, MOUTH BREATHING, ETC? _____

ANY LOST TEETH? _____

DOES YOUR CHILD BRUSH DAILY? _____

DO YOU ASSIST YOUR CHILD WITH BRUSHING? _____

HOW OFTEN? _____

IS DENTAL FLOSS USED? _____

ARE DISCLOSING TABLETS USED? _____

DOES YOUR CHILD RECEIVE FLUORIDE? _____

CHILD'S ATTITUDE TOWARDS DENTISTRY? _____

MEDICAL HISTORY

CHILD'S PHYSICIAN_____

PHYSICIAN ADDRESS_____

PHYSICIAN PHONE_____

DATE OF LAST PHYSICAL EXAM_____

RESULTS_____

IS YOUR CHILD IN GOOD HEALTH? _____

UNDER THE CARE OF A PHYSICIAN? _____

RECEIVING ANY MEDICATIONS OR DRUGS? PLEASE LIST:

_____

_____

CHILD'S WEIGHT _____ HEIGHT _____

HAS YOUR CHILD BEEN HOSPITALIZED? _____

HAS YOUR CHILD HAD SURGERY? _____

EATING HABITS PRESENTLY - BRIEFLY EXPLAIN:

_____

_____

ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION?

_____

_____

DOES YOUR CHILD HAS OR HAS HAD ANY OF THE FOLLOWING HEALTH RELATED PROBLEMS?

- ❑ AIDS OR HIV POSITIVE
- ❑ ALLERGIES _____
- ❑ ANEMIA OR BLOOD DISORDERS
- ❑ ANY PROLONGED BLEEDING OR BRUISES EASILY
- ❑ ARTHRITIS
- ❑ ASTHMA
- ❑ CANCER
- ❑ CONGENITAL HEART DISEASE OR HEART MURMUR
- ❑ CONVULSION, SEIZURES FAINTING OR EPILEPSY
- ❑ DIABETES
- ❑ GLANDULAR OR HORMONAL PROBLEMS
- ❑ HAY FEVER
- ❑ HEPATITIS
- ❑ HIGH BLOOD PRESSURE
- ❑ JAUNDICE
- ❑ KIDNEY OR BLADDER PROBLEMS
- ❑ LIVER PROBLEMS
- ❑ LOW BLOOD PRESSURE
- ❑ PNEUMONIA
- ❑ RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE
- ❑ SPEECH, LEARNING OR HEARING DISORDERS
- ❑ TUBERCULOSIS
- ❑ OTHER _____

IF YES TO ANY MEDICAL CONDITIONS PLEASE EXPLAIN

_____

_____

I AM INDICATING MY CONSENT FOR ROUTINE DENTAL PROCEDURES SUCH AS X-RAYS, CLEANING, FILLINGS, CROWS, AND LOCAL ANESTHESIA. I CERTIFY THAT I AM RESPONSIBLE FOR THE MEDICAL/DENTAL CARE OF THE MINOR.

_____

SIGNATURE OF PARENT/GUARDIAN

_____

DATE

PRECISION DENTAL

DATE_____

MEDICAL HISTORY UPDATE

DATE	COMMENTS	SIGNATURE