CHILD & YOUNG ADULT'S HISTORY

DATE _____

NAME _____ NICKNAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____
STREET CITY STATE ZIP

SCHOOL _____ GRADE _____ FAVORITE SUBJECT _____

FAVORITE ACTIVITY _____ FAVORITE TOY _____ FAVORITE FICTIONAL CHARACTER _____

FAVORITE TV PROGRAM _____ FAVORITE MUSIC OR GROUP _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

FATHER'S NAME _____ HOME PHONE (____) _____

ADDRESS IF DIFFERENT _____
STREET CITY STATE ZIP

EMPLOYED BY _____ OCCUPATION _____

ADDRESS _____ BUSINESS PHONE (____) _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

MAY WE CONTACT YOU AT WORK? _____ WHEN? _____

MOTHER'S NAME _____ HOME PHONE (____) _____

ADDRESS IF DIFFERENT _____
STREET CITY STATE ZIP

EMPLOYED BY _____ OCCUPATION _____

ADDRESS _____ BUSINESS PHONE (____) _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

MAY WE CONTACT YOU AT WORK? _____ WHEN? _____

IS THERE DENTAL INSURANCE OF WHICH WE NEED TO BE AWARE? _____

FATHER'S DENTAL INSURANCE CO. _____ GROUP NUMBER _____

MOTHER'S DENTAL INSURANCE CO. _____ GROUP NUMBER _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT _____ RELATION TO CHILD _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

_____

	YES	NO
Has child complained about dental problems _____	❑	❑
_____		
Any unhappy dental experience _____	❑	❑
_____		
Any injuries to mouth - teeth - head _____	❑	❑
_____		
Any mouth habits - thumbsucking, nail biting, mouth breathing nursing bottle habits, pacifier, etc. _____	❑	❑
_____		
_____		

	YES	NO
Does your child brush teeth daily _____	❑	❑
Do you assist child with tooth brushing _____	❑	❑
How often _____		
Is dental floss used _____	❑	❑
How often _____		
Are disclosing tablets used _____	❑	❑
Is Fluoride taken in any form _____	❑	❑
_____		

Child attitude to dentistry

_____

_____

_____

Do you desire complete dental service for the child	❑	❑

	YES	NO
Any unusual speech habits	❑	❑
Any lost teeth	❑	❑
Have missing teeth been replaced	❑	❑
Orthodontic appliances worn now or ever been	❑	❑

Summary (for doctor's use) _____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is child under care of physician now	❑	❑
Is child receiving any medications or drugs	❑	❑
Is there any excessive bleeding when cut	❑	❑
Has child ever been hospitalized	❑	❑
Has child ever had surgery	❑	❑

	YES	NO
Is there any allergy to penicillin or other drugs	❑	❑
Are there other allergies: food-pollen-animals-dust-other	❑	❑
Does child have good physical coordination	❑	❑
Are there any emotional problems	❑	❑

Summary (for doctor's use) _____

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

Yes	No		Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	Fainting	❑	❑	Mononucleosis
❑	❑	Asthma	❑	❑	Hearing	❑	❑	Mumps
❑	❑	Bladder	❑	❑	Heart	❑	❑	Rheumatic Fever
❑	❑	Cerebral Palsy	❑	❑	Kidney	❑	❑	Thyroid
❑	❑	Chronic Sinus	❑	❑	Liver	❑	❑	Tuberculosis
❑	❑	Convulsions	❑	❑	Malignancies	❑	❑	Other
❑	❑	Diabetes	❑	❑	Mastoid			
❑	❑	Epilepsy	❑	❑	Measles			

4 years of age	2 Occlusals (Maxillary and Mandibular)
5 years of age	2 Bite Wing X-Rays
6-9 years of age	Pedodontic Full Mouth X-Rays or
	Panorex (Orthodontic Consultation) or Bite Wing X-Rays
10-14 years of age	4 Bite Wing X-Rays
15-17 years of age	Panorex (Extraction of Third Molars) or Bite Wing X-Rays

The American Dental Association recommends fluoride treatments for children twice a year.

THE UNDERSIGNED CONSENTS TO THE DENTAL TREATMENT TO BE PROVIDED TO THE MINOR CHILD INCLUDING, BUT NOT LIMITED TO RADIOGRAPHS, PROPHYLAXIS, FLUORIDE TREATMENTS, EXTRACTIONS, RESTORATIVE PROCEDURES, AND OTHER TREATMENTS PROVIDED BY THIS OFFICE. THE UNDERSIGNED FURTHER GUARANTEES PROMPT PAYMENT OF ALL FEES AND CHARGES AS BILLED INCLUDING, BUT NOT LIMITED TO THOSE FEES AND CHARGES NOT COVERED BY INSURANCE, IF APPLICABLE.

SIGNATURE OF PARENT OR GUARDIAN: _____

RELATIONSHIP TO CHILD: _____

DATED: _____

SIGNATURE OF DENTIST/WITNESS: _____