Health History Form – Child

Patient Information

Patient's Name:_____ Age:_____ Birth date:_____

Name you like to be called: _____ School:_____ Grade:_____

Address:_____ City: _____ State:_____ Zip: _____

Home Phone#: _____Cell Phone #: _____ Social Security#_____

Email: _____

Whom may we thank for referring you to our office?_____

Parent/Legal Guardian Information

Name: _____ Home Phone#: _____Cell Phone #: _____

Address:_____ City: _____ State:_____ Zip: _____

Time at this residence: _____Marital Status: _____ Relationship to patient: _____

Employer: _____ Occupation:_____ # of years employed: ____

Name: _____ Home Phone#: _____Cell Phone #: _____

Address:_____ City: _____ State:_____ Zip: _____

Time at this residence: _____Marital Status: _____ Relationship to patient: _____

Employer: _____ Occupation:_____ # of years employed: ____

Dental Insurance Information

Please provide all information in order to accurately verify insurance benefits

Insured's Name: _____ Insured's SS#: _____ Insured's DOB:_____

Insurance Member ID:_____ Group#:_____Insurance Co: _____

Insurance Co. Address: _____

Phone: _____ Insured's Employer: _____

Do you have dual coverage? ☐Yes ☐No If yes,

Insured's Name: _____ Insured's SS#: _____ Insured's DOB:_____

Insurance Member ID:_____ Group#:_____Insurance Co: _____

Insurance Co. Address: _____

Phone: _____ Insured's Employer: _____

Medical/Dental History

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

☐Yes ☐No Is the patient currently under any medical treatment? If so, what kind?_____

☐Yes ☐No Does the patient you have pain, clicking, and/or popping noises in the jaw?

☐Yes ☐No Is the patient aware of either clenching or grinding of teeth? History of night guard? ☐ Yes ☐ No

☐Yes ☐No Does the patient have frequent headaches? How often? _____

☐Yes ☐No Does the patient have ear problems? (aches, ringing, dizziness, fullness)

☐Yes ☐No Does the patient have difficulty breathing through the nose?

☐Yes ☐No Does the patient have habits such as nail biting, finger or thumb sucking, lip or cheek biting?

☐Yes ☐No Does the patient have speech problems, or are you in speech therapy?

☐Yes ☐No Has the patient had your tonsils and/or adenoids removed?

☐Yes ☐No Has there been any history of: ☐ Joint swelling ☐ Asthma ☐ TB ☐ Aids ☐ HIV
☐ Kidney ☐ Liver Condition ☐ Epilepsy ☐ Rheumatic fever
☐ Other major illnesses? _____

☐Yes ☐No Does the patient bleed easily? Anemic: ☐ yes ☐ no

☐Yes ☐No Is there a tendency to faint or become dizzy?

☐Yes ☐No Does the patient have allergies? (LATEX, sulphur, penicillin, novocaine, etc.) _____

☐Yes ☐No Is the patient currently taking any medication? List: _____

☐Yes ☐No Has there been a history of growth hormone therapy? If so when and how long? _____

☐Yes ☐No Does the patient have a heart condition? Cardiologist_____

☐ Yes ☐No Does the patient pre-medicate?

☐Yes ☐No Is the patient currently pregnant? If yes, what is the due date: _____
Date of first menstrual cycle: _____

☐Yes ☐No Has the patient been diagnosed with sleep apnea? If so do you use CPAP machine? ☐ Yes ☐ No

☐Yes ☐No Does the patient smoke or chew tobacco? Quantify Usage: _____

☐Yes ☐No History of facial trauma or injuries to the teeth? Explain: _____

☐Yes ☐No Has the patient had any permanent teeth, other than wisdom teeth, extracted? If yes: _____

☐Yes ☐No Have we treated any other family members? Who: _____

Any other medical concerns not listed above: _____

Signature: _____Date:_____