WATERFORD FAMILY DENTAL  **CHILD HEALTH HISTORY**

Date: _____

Patient Name:_____ Prefers to be called_____

Sex: ☐ Male ☐ Female Birthdate: _____ Age: _____

Home Address: _____

_____ _____
City State Zip

Home #: _____

Mother/Father Information

Mother's name: _____ Birthdate: _____

Home#: _____ Cell#: _____

SS#: _____ Email: _____

Father's name: _____ Birthdate: _____

Home#: _____ Cell#: _____

SS#: _____ Email: _____

How would you like to be confirmed for your child's appointment? ☐ Phone ☐ Email ☐ Text Message

If text message who is your cell phone provider:

☐ US Cellular ☐ Verizon ☐ Sprint ☐ AT&T ☐ T-Mobile ☐ Other_____

Person Responsible for Account

☐ Mother ☐ Father ☐ Other (fill out below)

Name: _____ Birthdate:_____

Home Address: _____

_____
City State Zip

Home#: _____ Cell#: _____

SS#: _____ Relationship:_____

WATERFORD FAMILY DENTAL **CHILD HEALTH HISTORY**

Dental History

Previous / Present Dentist: _____ Date last seen: _____

Why did the child come to the dentist today? _____

_____

Does the child have a history of cold sores or fever blisters? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking a fluoride supplement? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush their teeth daily? ☐ Yes ☐ No

Does the child floss their teeth daily? ☐ Yes ☐ No

Allergies

Is the child allergic to any of the following? (please circle)

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline

Please list any other drugs/materials that the child may be allergic to: _____

_____

Does/did the child have any of the following habits:

Lip Sucking/Biting	☐ Yes ☐ No	Nursing/ Bottle Habits	☐ Yes ☐ No
Nail Biting	☐ Yes ☐ No	Thumb/Finger Sucking	☐ Yes ☐ No

Medical History

Your child's current physical health is: ☐ Good ☐ Fair ☐ Poor

Child's Physician: _____

Phone #: _____ Date of last visit: _____

WATERFORD FAMILY DENTAL **CHILD HEALTH HISTORY**

Is the child currently under the care of a physician? ☐ Yes ☐ No

If Yes, please explain:

_____

_____

Is the child taking any prescription drugs? ☐ Yes ☐ No

Is the child taking any over-the-counter drugs or herbal supplements? ☐ Yes ☐ No

Please list each one:

_____

_____

Has the child ever had any of the following diseases or medical problems?

Abnormal Bleeding	☐ Yes ☐ No	ADD/ADHD	☐ Yes ☐ No
Any hospital Stays	☐ Yes ☐ No	Any Operations	☐ Yes ☐ No
Artificial Bones/Joints/Valves	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No	**Congenital Heart Defect**	☐ Yes ☐ No
Convulsions/Epilepsy	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Handicaps/Disabilities	☐ Yes ☐ No	Hearing Impairment	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	HIV+ / AIDS	☐ Yes ☐ No
Hospitalized for any reason	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Rheumatic/Scarlet Fever	☐ Yes ☐ No
Sickle Cell Disease/Traits	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Please list any serious medical problems that the child has ever had:

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

_____ _____

Signature Date