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: _____ Who 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: _____

Social Security #: _____ Birth date:_____ Email: _____

Employer: _____ Occupation:_____ No. of years employed:_____

*Name: _____ Home Phone# _____ Cell Phone # _____

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

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

Social Security #: _____ Birth date:_____ Email: _____

Employer: _____ Occupation:_____ No. of years employed:_____

Dental Insurance Information – Please Provide All Information In Order To accurately verify benefits

Insured 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 Name: _____Insured SS#_____

Insured member id:_____ Group #: _____ Insurance Co: _____

Insured's Employer:_____ Insurance Co. Address:_____

Medical/Dental History

Physician's Name:_____ Phone:_____

Dentists Name: _____ Phone:_____

☐Yes ☐No Are you currently under any medical treatment? If So What Kind?_____

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

☐Yes ☐No Are you aware of either clenching or grinding of teeth? History of Night Guard? ☐yes ☐no

☐Yes ☐No Do you have frequent headaches? How often?_____

☐Yes ☐No Do you have ear problems? (Aches, ringing, dizziness, fullness)

☐Yes ☐No Do you have difficulty breathing through the nose?

☐Yes ☐No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?

☐Yes ☐No Do you have speech problems, or are you in speech therapy?

☐Yes ☐No Have you 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 Do you bleed easily? Anemic: ☐yes ☐no

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

☐Yes ☐No Do you have allergies? (LATEX, Sulphur, penicillin, novocaine, etc.)_____

☐Yes ☐No Are you currently taking any medication? List:_____

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

☐Yes ☐No Do you have a heart condition? Do you pre-medicate? ☐Yes ☐No Cardiologist:_____

☐Yes ☐No Are you currently pregnant? If yes, what is the due date? _____

Date of first menstrual cycle: _____

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

☐Yes ☐No Do you smoke or chew tobacco? Quantify Usage: _____

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

☐Yes ☐No Have you had any permanent teeth, other than wisdom teeth, extracted? _____

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

Any other medical concerns not listed above: _____

Signature: _____Date: _____