

hild Health/Dental History Form



For completion by dentist Comments					W	ww.ada.org	
Price Pric		EIDST	INITIAL	Nickname	Date of Birth		
Honore Have you the parent/guardian) or the patient had any of the following diseases or problems? Active fuborouses. 2. Persistent cough opatient than a time-work duration. 3. Cought that produces bood? If you answer yes to any of the three items above, please stop and return this form to the receptionist. Has the child had any history of, or conditions related to, any of the following: Anenia Cancer Fplepsy HV -/AIDS Arthitic Coreba Paloy Friends and immunications Manage introduced to Arthitic Coreba Paloy Friends introduced i		11101	11 VI 1 II Va	Relationship to Patient	1		
Here you the peeningardian) or the patent had any of the folioning diseases or problems?	Address						
Items Note Description	PO OR MAILING ADDRI	ESS		CITY	STATE	ZIP CODE	
Active Tubercucies, 2 Persistent outging greater than a three-week duration, 3 Cough that produces blood?			Work		Sex M F		
Annexia Cancer Epipapy HIV +/AIDS Mononucleosis Thyroid Arthritis Cembrial Palay Fairling Immunizations Murrys Tuberculosis Bladder Chrock Structs Hearing Latx allergy Pregnancy (teans) TobaccoOffing Use Bladder Chrock Structs Hearing Latx allergy Phenumate fever Vennead Desease Bleeding disorders Diabetes Heari Liver Seizurus Other Desease Bleeding disorders Diabetes Hearing Latx allergy Phenumate fever Vennead Desease Bleeding disorders Diabetes Hearing Latx allergy Phenumate fever Vennead Desease Bleeding disorders Diabetes Physicians Phone International Physicians Phone Physicians Phone Physicians Phone Physician Phone Physicians Phone International Physicians Phone International Physician Internation	Have you (the parent/guardian) or the patient had any of the following diseases or problems?						
Annmia Cancer Epilocoy HIV +/AIDS Mononuclocals Thyroid Arthrilis Coretral Palaty Fainting Immurizations Murrys Tuberculosis IndeatocolOring Use Bladder Chroic Sinustitis General Palaty Personal Palaty Programmer Program	Has the child had any history of, or conditions related to, any of the following:						
Name of Physician	Anemia Arthritis Asthma Bladder Bleeding disorders	Cancer Cerebral Palsy Chicken Pox Chronic Sinusitis Diabetes	Epilepsy Fainting Growth Problems Hearing Heart	HIV +/AIDS Immunizations Kidney Latex allergy Liver	Mumps Pregnancy (teens) Rheumatic fever Seizures	Tobacco/Drug Use Tuberculosis Venereal Disease	
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: 2. Is the child allergic to any thing else, such as certain foods? If yes, please explain: 3. 4. How would you describe the child's eating habits? 5. Has the child ever had a serious illness? If yes, when: 6. Has the child ever had a serious illness? If yes, when: 7. Does the child have a history of any other illnesses? If yes, please list: 7. As the strict of the ever been hospitalized? 7. Does the child have a history of any other illnesses? If yes, please list: 7. As the strict of the dever been boot transhusion? 9. Does the child have any speech difficulties? 9. Does the child have any speech difficulties? 9. Does the child have any speech difficulties? 9. List the child ever had a blood transhusion? 2. Is the child physically, mentally, or emotionally imparred? 2. Is the child physically mentally or emotionally imparred? 3. Step the child any problem with dental treatment in the past? 4. Is the child currently being treated for any illnesses? 5. Has the child ever had a brild any problem with dental treatment in the past? 6. Has the child dever had ental radiographs (x-rays) exposed? 7. Has the child ever had ental radiographs (x-rays) exposed? 7. Has the child dever had ental radiographs (x-rays) exposed? 7. Has the child had any problem with dental treatment in the past? 8. Has the child had any problems with dental treatment in the past? 9. Has the child had any problems with dental treatment in the past? 9. Has the child had any problems with the enuption or shedding of teeth? 9. Has the child had any problems with the enuption or shedding of teeth? 9. Has the child had any problems with the enuption or shedding of teeth? 9. Has the child had any orthodontic treatment? 9. Has the child had any orthodontic treatment? 9. Has the child had the problems with	Please list the name and phone number of the child's physician:						
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? Is the child laterigo to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: 2. Is the child allergic to anything else, such as certain foods? If yes, please explain: 3. 4. How would you describe the child's eating habits? 5. Has the child ever had a serious illness? If yes, when: 6. Has the child ever bean hospitalized? 7. Does the child have a history of any other illnesses? If yes, please list: 7. As the shild ever received a general anesthetic? 8. Has the child ever received a general anesthetic? 9. Does the child have any speech difficulties? 9. Does the child have any speech difficulties? 9. Does the child have any speech difficulties? 9. Does the child ever had a blood translusion? 2. Is the child physically, mentally, or emotionally impaired? 2. Is the child physically mentally, or emotionally impaired? 2. Is the child appraised excessive bleeding when cut? 3. Is this the child currently being treated for any illnesses? 4. Is the child during the problem with dental treatment in the past? 5. Has the child ever had derilar radiographs (x-rays) exceed? 7. Has the child ever had derilar radiographs (x-rays) exceed? 7. Has the child ever had derilar radiographs (x-rays) exceed? 7. Has the child ever had derilar radiographs (x-rays) exceed? 7. Has the child ever had derilar radiographs (x-rays) exceed? 7. Has the child had any problem with dental treatment in the past? 8. Has the child had any problem with dental restiment in the past? 9. Has the child had any problem with dental restiment in the past? 9. Has the child had any orthodonic treatment? 9. Has the child had any orthodonic treatment? 9. Has the child about the restimant and problems with the exception of shedding of teeth? 9. Has the child had any orthodonic treatment? 9. Has the child had any orthodonic treatment? 9. Has the child had any orthodonic treatment? 9. Does the	Name of Physician				Phone		
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4. Is the child currently being treated for any illnesses?	Is the child taking any If yes, please list: Is the child allergic to a series of the child allergic to a series. Is the child allergic to a series of the child ever had series of the child ever been on the child ever been on the child ever recesus of the child ever had series of the child have an one of the child ever had the child ever had the child ever had the child physically, in the child ever had the child physically, in the child physically.	iny medications, i.e. penic inything else, such as cert be the child's eating habits a serious illness? If yes, von hospitalized? history of any other illness ived a general anesthetic' y inherited problems? y speech difficulties? a blood transfusion?	illin, antibiotics, or other cain foods? If yes, please s? Please se? If yes, please list:?	drugs? If yes, please exp explain:ease describe:	lain:	2. 3. 5. 6. 7. 8. 9. 0	
5. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: 6. Has the child had any problem with dental treatment in the past? 7. Has the child ever had dental radiographs (x-rays) exposed? 8. Has the child ever suffered any injuries to the mouth, head or teeth? 8. Has the child had any problems with the eruption or shedding of teeth? 9. Has the child had any problems with the eruption or shedding of teeth? 20. Has the child had any orthodontic treatment? 20. Has the child take fluoride supplements? 21. What type of water does your child drink? City water Well water Bottled water Filtered water 22. Does the child take fluoride supplements? 23. Is fluoride toothpaste used? 24. How many times are the child's teeth brushed per day? 25. Does the child suck his/her thumb, fingers or pacifier? 26. At what age did the child stop bottle feeding? Age 27. Does child participate in active recreational activities? 27. OTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. 1 certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. 1 Parent's/Guardian's Signature 1 Date 1 For completion by dentist 1 Comments 1 Comments							
7. Has the child ever had dental radiographs (x-rays) exposed?	5. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date:						
8. Has the child ever suffered any injuries to the mouth, head or teeth?							
9. Has the child had any problems with the eruption or shedding of teeth?							
21. What type of water does your child drink? City water Well water Bottled water Filtered water 22. Does the child take fluoride supplements?	9. Has the child had any	problems with the eruption	n or shedding of teeth?			9.	
22. 33. Is fluoride toothpaste used?						20.	
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Comments	Parent's/Guardian's SignatureDate						
FOLUNICE USE CODY: MICROSTATION PREMIEDICATION Allerdies Abestinesia Reviewed DV							

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