

**CONFIDENTIAL MEDICAL AND DENTAL HISTORY**

Child's Name \_\_\_\_\_

Nickname \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Names and ages of brothers and sisters \_\_\_\_\_

	Yes	No
Does either parent wear dentures?	_____	_____

Does either parent have a family history of	A. Impacted teeth	_____	_____
	B. Extra tooth	_____	_____
	C. Inherited absence of a tooth (teeth)	_____	_____
	D. Crooked teeth (orthodontic problems)	_____	_____

	Mother	Father
How do you and your spouse feel about dental care for yourselves		
Excellent and Comfortable	_____	_____
Mildly Nervous	_____	_____
Fearful	_____	_____

Does this child have a health problem?  Yes  No If yes, describe \_\_\_\_\_

Has this child ever been hospitalized?  Yes  No If yes, please list dates and reasons \_\_\_\_\_

Has your child had any history of the following? (Please check if yes)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Kidney or Liver Disease | <input type="checkbox"/> Psychological or Emotional Problems |
| <input type="checkbox"/> Heart Trouble               | <input type="checkbox"/> Allergies               | <input type="checkbox"/> Sickle Cell Disease or Trait        |
| <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Blood Transfusion                   |
| <input type="checkbox"/> Anemia or Bleeding Problems | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> HIV/AIDS                            |
| <input type="checkbox"/> Lung or Breathing Problems  | <input type="checkbox"/> Fainting or Convulsions | <input type="checkbox"/> Hepatitis                           |

	Yes	No
Has this child had any unfavorable reaction to any medicine such as Penicillin, Aspirin or Local Anesthetic?	_____	_____

Is this child taking any medication now? If yes, what? \_\_\_\_\_

Is your drinking water fluoridated? \_\_\_\_\_

Does this child take fluoride or fluoride vitamins? \_\_\_\_\_

Does this child have a finger, thumb or pacifier habit? \_\_\_\_\_

Does this child have dental problems \_\_\_\_\_

If this child has been to the dentist before, please describe his/her reaction and what was done \_\_\_\_\_

Is there anything else you would like to tell us about your child? \_\_\_\_\_

Child's Physician \_\_\_\_\_ Child's Former Dentist \_\_\_\_\_

Referred By \_\_\_\_\_

Chief complaint at this time \_\_\_\_\_

What prompted you to bring your child to our office? \_\_\_\_\_

Email Address \_\_\_\_\_

Primary Dental Insurance Company Name \_\_\_\_\_ Group # \_\_\_\_\_

Insur. Address \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Secondary Dental Insurance Company Name \_\_\_\_\_ Group # \_\_\_\_\_

Insur. Address \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_ Parent/Guardian Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian Home Phone \_\_\_\_\_ Parent/Guardian Home Phone \_\_\_\_\_

SINGLE       MARRIED       WIDOWED       DIVORCED       SEPARATED

Parent/Guardian Employer \_\_\_\_\_ Parent/Guardian Employer \_\_\_\_\_

Parent/Guardian Occupation \_\_\_\_\_ Parent/Guardian Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Please list the best number to reach you during the day in case of emergency \_\_\_\_\_

How would you prefer to be confirmed?

Home \_\_\_\_\_

Cell \_\_\_\_\_

Email \_\_\_\_\_

I have received a copy of this office's Notice of Privacy Practices.

Name (print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

----- **OFFICE USE ONLY** -----

\_\_\_\_ Patient/Guardian refused to sign

\_\_\_\_ Communications barriers prohibited obtaining the acknowledgement

\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_\_ Other (describe) \_\_\_\_\_