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)	_____	_____

How do you and your spouse feel about dental care for yourselves	Mother	Father
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)

☐ Heart Murmur	☐ Kidney or Liver Disease	☐ Psychological or Emotional Problems
☐ Heart Trouble	☐ Allergies	☐ Sickle Cell Disease or Trait
☐ Rheumatic Fever	☐ Asthma	☐ Blood Transfusion
☐ Anemia or Bleeding Problems	☐ Diabetes	☐ HIV/AIDS
☐ Lung or Breathing Problems	☐ Fainting or Convulsions	☐ Hepatitis

	Yes	No
Are your child's immunizations up to date?	_____	_____
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 supplements?	_____	_____
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?_____

OVER

Primary Dental Insurance Company Name_____Group #_____

Insurance Address_____

Policy Holder's Name_____

Insurance ID#_____ Policy Holder's Date of Birth_____

Secondary Dental Insurance Company Name_____Group #_____

Insurance Address_____

Policy Holder's Name_____

Insurance ID#_____ Policy Holder'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_____

Email address_____ Email address_____

Please list the best number to reach you during the day in case of emergency_____

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)_____