Patient Health Information

Child's name: _____ Date of Birth: _____
First / MI / Last *Month / Date / Year*

☐ Male ☐ Female Child's Doctor/Pediatrician: _____

Who referred you to our office? _____

Names of other children in your family that we have seen: _____

_____

Health History:

Has child been seen by another dentist? ☐ Yes ☐ No If yes, when was their last visit? _____
Month / Year

Please list name of dentist/clinic: _____

What was his/her reaction? _____

Is your child currently having dental problems? ☐ Yes ☐ No explain: _____

_____

Is your water fluoridated? ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

List any serious operations/illness/syndrome/medical conditions your child has/had: _____

_____

_____

Please check if your child has/had any of the following:

☐ Heart Murmur	☐ Heart Disease	☐ Tuberculosis	☐ Congenital Heart Defects
☐ Hepatitis	☐ Asthma	☐ Rheumatic Fever	☐ Cancer/Tumor
☐ Diabetes	☐ Bleeding Disorder	☐ Seizures/Epilepsy	☐ HIV/AIDS

Child Development: ☐ Congenital/Developmental Abnormality ☐ ADHD

☐ Autism ☐ ADD

Allergies: ☐ Latex

☐ Seasonal/Environmental _____

☐ Food _____

☐ Medication _____

List any medication(s) your child is currently taking: _____

_____

Is your child currently in good health? ☐ Yes ☐ No