Valley Dental Center

Child Health / Dental History Form

Parent / Guardian's E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you and your child that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning the health of your child. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient's Name (LAST FIRST MIDDLE INITIAL) Nickname Date of Birth Sex: M ☐ F ☐

Parent's / Guardian's Name Relationship to Patient

Address City State Zip

Home Phone Work Phone Cell Phone

Have you (parent/guardian) or the patient had any of the following diseases or problems? **Yes** ☐ **No** ☐

☐ Active Tuberculosis ☐ Persistent Cough Greater Than Three Weeks Duration ☐ Cough That Produces Blood

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:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco / Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bleeding Disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other _____
☐ Bones / Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle Cell	

Please list the name and phone number of the child's physician:

Name of Physician Phone:

Child's History

Please mark (X) as yes or no responses and provide details to the following questions.

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, Please list:	☐	☐
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain:	☐	☐
3.	Is the child allergic to anything else such as certain foods? If yes, please explain:	☐	☐
4.	How would you describe the child's eating habits?	☐	☐
5.	Has the child ever had a serious illness? If so, when? Please describe	☐	☐
6.	Has the child ever been hospitalized? If so, when?	☐	☐
7.	Does the child have a history of any other illness? If yes, Please list:	☐	☐
8.	Has the child ever received a general anesthetic?	☐	☐
9.	Does the child have any inherited problems?	☐	☐
10.	Does the child have any speech problems? If yes, Please list:	☐	☐
12.	Is the child physically, mentally, or emotionally impaired?	☐	☐
13.	Does the child experience excessive bleeding when cut?	☐	☐
14.	Is the child currently being treated for any illness? If yes, Please describe:	☐	☐
15.	Is this the child's first visit to a dentist? If not, what was the date of the last dental visit? Date:	☐	☐
16.	Has the child ever had any problem with dental treatment in the past?	☐	☐
17.	Has the child ever had dental radiographs (x-rays) exposed?	☐	☐
18.	Has the child ever suffered any injuries to the mouth, head, or teeth? If so, when?	☐	☐
19.	Has the child had any problems with the eruption or shedding of teeth?	☐	☐
20.	Has the child had any orthodontic treatment?	☐	☐
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.	**Does the child use fluoride toothpaste?**	☐	☐
24.	How many times are the child's teeth brushed per day? When are the teeth brushed?	☐	☐
25.	Does the child suck his/her thumb, fingers, or pacifier? Date:	☐	☐
26.	At what age did the child stop bottle feeding? Age: Breast feeding? Age:		
27.	Does the child participate in regular recreational activities?	☐	☐

NOTE: Both doctor and patient or guardian are encouraged to discuss any and all relevant health issues or concerns prior to treatment.

I 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.

Parent's / Guardian's Signature Date

For Comments - Completion by Dentist

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed By Date