

Child Health History

Ages 0-12



Section 1 – Tell Us About Your Child

Child's Name: _____ Today's Date: ____/____/____
LAST FIRST MI

What child prefers to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Mailing Address: _____

Home Phone #: (____) _____

CITY STATE ZIP

School: _____ Grade: _____ Hobbies: _____

Section 2 – Parent's Information

Parent's Marital Status: Minor Single Married Divorced Separated Widowed

Father Step Father Guardian

Name: _____ Birthdate: ____/____/____ SS#: _____

Mailing Address (if different than child's): _____

DL# _____

CITY STATE ZIP

Home Phone #: (____) _____ Work Phone #: (____) _____ Ext.: _____

Cell Phone #: (____) _____ Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

CITY STATE ZIP

If you have dental insurance for the child please fill out below:

Company Name: _____

Address: _____

Phone #: (____) _____

CITY STATE ZIP

Insured's SS#: _____ Group # (Plan, Local or Policy #): _____

Mother Step Mother Guardian

Name: _____ Birthdate: ____/____/____ SS#: _____

Mailing Address (if different than child's): _____

DL# _____

CITY STATE ZIP

Home Phone #: (____) _____ Work Phone #: (____) _____ Ext.: _____

Cell Phone #: (____) _____ Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

CITY STATE ZIP

If you have dental insurance for the child please fill out below:

Company Name: _____

Address: _____

Phone #: (____) _____

CITY STATE ZIP

Insured's SS#: _____ Group # (Plan, Local or Policy #): _____

Section 3 – Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

Section 4 – General Information

Who is accompanying the child today? _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we thank for referring you? _____

Other siblings: _____

Previous Dentist (if applicable) _____ (_____) _____
NAME PHONE #

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Relative or Friend not living with you:

Name: _____ Phone: (_____) _____

Address: _____

CITY _____ STATE _____ ZIP _____

Section 5 – Dental & Medical History

Why did you bring your child to the dentist today? _____

Is the child currently in pain? Yes No Does the child require antibiotics before dental treatment? Yes No

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No Floss his/her teeth daily? Yes No

Child's Physician: _____ Phone #: (_____) _____ Date of Last Visit: ____/____/____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health: Good Fair Poor

Please list all drugs that the child is currently taking: _____

Please list all drugs/things the child is allergic to: _____

Has the child experienced any of the following medical problems? (circle yes (Y) or no (N))

Y	N	Anemia	Y	N	Any Hospital Stays/Operations?	Y	N	Chicken Pox	Y	N	Abnormal Bleeding
Y	N	Cancer	Y	N	Artificial Bones/Joints/Valves	Y	N	AIDS/HIV+	Y	N	Heart Murmur
Y	N	Diabetes	Y	N	Handicaps/Disabilities	Y	N	Convulsions	Y	N	Rheumatic Fever
Y	N	Asthma	Y	N	Congenital Heart Defect	Y	N	Liver Problems	Y	N	Low Blood Pressure
Y	N	Hives	Y	N	Exposed to HIV, but Neg.	Y	N	Mononucleosis	Y	N	Kidney Problems
Y	N	Measles	Y	N	Hearing Impairment	Y	N	Skin Rash	Y	N	Scarlet Fever
Y	N	Epilepsy	Y	N	High Blood Pressure	Y	N	Hemophilia	Y	N	Prosthetics
Y	N	Hepatitis	Y	N	Mitral Valve Prolapse	Y	N	ADD/ADHD	Y	N	Tuberculosis (TB)

Are the child's immunizations current? Yes No Anything you would like to discuss with the Doctor in private? Yes No

Please discuss any serious medical problems the child experiences(ed): _____

Does the child have any of the following behaviors? (circle yes (Y) or no (N))

Y	N	Breast Fed	Y	N	Chewing on Objects	Y	N	Clenching/Grinding Teeth	Y	N	Lip Sucking/Biting
Y	N	Mouth Breather	Y	N	Nail Biting	Y	N	Nursing Bottle Habits	Y	N	Speech Problems
Y	N	Thumb/Finger Sucking	Y	N	Tongue/Cheek Biting	Y	N	Tongue Thrust	Y	N	Used Pacifier

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services as my child may need.

_____/_____/_____
 Signature of Parent or Guardian Date

Welcome to Mondale Dental!

Office Use Only
 I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.
 _____/_____/_____
 Signature of Dentist Date
 Dentist's Comments: _____

Medical History Update
 Has there been any change in your child's health status since their last visit?
 _____/_____/_____
 Parent/Guardian Signature Date Dentist Signature Date
 Has there been any change in your child's health status since their last visit?
 _____/_____/_____
 Parent/Guardian Signature Date Dentist Signature Date