Child Health/Dental History Form

ADA American Dental Association®

America's leading advocate for oral health

Address POOTMALAD ACRESS ADDRESS ADDRE	Patient's Name			Nickname	Dat	e of Birth			-
Address Proce Note: Note: Sex M F Sex M F Have you the posterify, and any of the following diseases or problems? 1. Acther Liberculosis, 2. Pensistent cough greater than a three-week duration. 3. Cough that produces blood? 1. Acther Liberculosis, 2. Pensistent cough greater than a three-week duration. 3. Cough that produces blood? 1. Acther Liberculosis, 2. Pensistent cough greater than a three-week duration. 3. Cough that produces blood? 1. Acther Liberculosis, 2. Pensistent cough greater than a three-week duration. 3. Cough that produces blood? 1. Acther Liberculosis, 2. Pensistent cough greater than 3. P			TWO WILLIAM STATE OF SHALL						
Second S	Parent's/Guardian's Name			Relationship to Patient					
Have you the perent/guardan) or the patient had any of the following diseases or problems?				'					
New you the parent/pusedion) or the patient had any of the following diseases or problems?		DRESS		CITY					
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Oxogin that produces blood? If you answer yes to any of the times 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: Armina			Work			, -	-		
Description Control	Active Tuberculosis, 2 If you answer yes to any	 Persistent cough greater of the three items above 	r than a three-week durations, please stop and return	on, 3.Cough that produce n this form to the reception	s blood?		Yes	□ N	
Child's History 1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? 1. If yes, please list: 2. Is the child alergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: 2. Is the child alergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: 3. Is the child alergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: 3. Is the child alergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: 4. How would you describe the child's eather pablis? 5. Has the child ever had a serious illness? If yes, when: 6. Is the child ever had a serious illness? If yes, when: 7. Does the child have a history of any other illnesses? If yes, please list: 7. Does the child have a ny speech difficulties? 8. Is the child ever had a blood transfusion? 9. Does the child have any inherited problems? 9. Does the child have any speech difficulties? 10. Does the child have any speech difficulties? 11. Is the child physically, mentally, or emotionally impaired? 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 illnesses? 15. Is this the child currently being treated for any illnesses? 16. Is the stable dever suffered any injuries to the mouth, head or testin? 17. Is the child had any problem with the number of his visit was the date of the last dentist visit? Date: 18. Is the child had any problem with the number of his head or testin? 19. Is the child had any problem with the number of his head or testin? 19. Is the child had any problem with the number of his head or testin? 19. Is the child had any problem with the number of his head or testin? 19. Is the child had any problem with the number of his head or testin? 19. Is the child had any problems with the experience excession an	□ Anemia □ Arthritis □ Asthma □ Bladder □ Bleeding disorders	☐ Cancer ☐ Cerebral Palsy ☐ Chicken Pox ☐ Chronic Sinusitis ☐ Diabetes	☐ FIV +/AIDS ☐ Immunizations ☐ Kidney ☐ Latex allergy ☐ Liver	☐ Mumps☐ Pregnancy☐ Rheumatio☐ Seizures	 ☐ Mumps ☐ Tobacco/Drug Use ☐ Tuberculosis ☐ Tuberculosis ☐ Venereal Disease ☐ Seizures ☐ Other 				
Ves N 1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? 1. Is the child latergo to any medications, i.e. penicilin, antibiotics, or other drugs? If yes, please explain: 2. Is the child allergo to any medications, i.e. penicilin, antibiotics, or other drugs? If yes, please explain: 3. Is the child allergo to any medications, i.e. penicilin, antibiotics, or other drugs? If yes, please explain: 3. Is the child allergo 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 yes, when: 7. Does the child have a history of any other illnesses? If yes, please list: 7. Does the child have any speech difficulties? 9. Does the child have any speech difficulties? 10. Does the child have any speech difficulties? 11. In It is the child ever had a blood transfusion? 12. Is the child ever had a blood transfusion? 13. In It is the child physically, mentally, or emotionally impaired? 14. In It is child currently being treated for any illnesses? 15. Is this the child currently being treated for any illnesses? 16. In It is the child any problem with dental treatment in the past? 17. In It is the child ever had any problem with dental treatment in the past? 18. In It is the child ever had any problem with dental treatment in the past? 19. In It is the child ever had any problem with dental treatment in the past? 19. In It is the child ever had entail radiographs ke rays) exposed? 19. In It is the child ever had any problem with dental treatment in the past? 20. Does the child dark any problem with dental treatment in the past? 21. Is this the othild ever had ental radiographs ke rays) exposed? 22. In It is the child ever had entail radiographs ke rays) exposed? 23. Is fluorided by end and entail radiographs ke rays) exposed? 24. In It is the child ever had entail radiographs ke rays) exposed? 25. Does the child dark fluoride supplemen		d phone number of the o	hild's physician:						
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at mis time? 1. If yes, please list: 2. Is the child allergic to any medications, i.e. penicilin, 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 yes, when: 7. Does the child have a history of any other illnesses? If yes, please list: 7. Does the child have any speech difficulties? 8. Does the child have any speech difficulties? 9. Does the child have any speech difficulties? 9. Does the child have any speech difficulties? 11. Has the child ever read a blood transfusion? 12. Is the child physically, mentally, or emotionally impaired? 13. Does the child ever read a blood transfusion? 14. Is the child durernetly being treated for any illnesses? 15. Is this the child fourernetly being treated for any illnesses? 16. Has the child ever any linesses? 17. In this she child ever any linesses? 18. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a blood transfusion? 19. In this she child ever had a dential radiographs k-rays) exposed? 19. In this she child ever had dential radiographs k-rays exposed? 19. In this she child ever had ever indend any orthodontic treatment? 19. In this she child ever had dential radiographs k-rays exposed? 19. In this she child ever had a dential radiographs k-rays exposed? 19. In	Name of Physician				Pho	one			
5. Has the child ever had a serious illness? If yes, when: Please describe: 5. □ C. Has the child ever been hospitalized? 5. □ C. Has the child have a history of any other illnesses? If yes, please list: 7. □ C. Has the child have an history of any other illnesses? If yes, please list: 7. □ C. Has the child have any speech difficulties? 8. □ C. Does the child have any speech difficulties? 9. □ C. Does the child dave and a blood transfusion? 11. □ C. Does the child dexperience excessive bleeding when cut? 12. □ C. Does the child experience excessive bleeding when cut? 13. □ C. Does the child experience excessive bleeding when cut? 14. □ C. Does the child experience excessive bleeding when cut? 15. □ C. Does the child sproke the child stirst visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: 15. □ C. Does the child stirst visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: 15. □ C. Does the child experience excessive bleeding when cut? 15. □ C. Does the child shad any problem with dental treatment in the past? 16. □ C. Does the child shad any problems with the eruption or shedding of teeth? 17. □ C. Does the child had any problems with the eruption or shedding of teeth? 19. □ C. Does the child had any orthodorulic treatment? 19. □ C. Does the child had any orthodorulic treatment? 19. □ C. Does the child had any orthodorulic treatment? 19. □ C. Does the child take fluoride supplements? 19. □ C. Does the child take fluoride supplements? 19. □ C. Does the child take fluoride supplements? 19. □ C. Does the child such his/her thumb, fingers or pacifier? 19. □ C. Does the child such his/her thumb, fingers or pacifier? 19. □ C. Does child participate in active recreational activities? 19. □ C. Does child participate in active recreational activities? 19. □ C. Does child participate in active recreational activities? 19. □ C. Does child participate in active recreational activities? 19. □ C. Does child had because of errors or or or or	Is the child taking an lf yes, please list: Is the child allergic to 3. Is the child allergic to a list.	any medications, i.e. pe anything else, such as of	nicillin, antibiotics, or othe ertain foods? If yes, pleas	er drugs? If yes, please exp se explain:	olain;		2		No □
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	5. Has the child ever ha 6. Has the child ever be 7. Does the child have a 8. Has the child ever re 9. Does the child have a 10. Does the child have a 11. Has the child ever ha 12. Is the child eyer ha 13. Does the child experi 14. Is the child experi 15. Is this the child experi 16. Has the child had an 17. Has the child ever ha 18. Has the child ever ha 19. Has the child ever ha 19. Has the child had an 20. Has the child had an 21. What type of water 22. Does the child take 23. Is fluoride toothpas 24. How many times are 25. Does the child suck is 26. At what age did the colors.	d a serious illness? If yes en hospitalized?	impaired? when cut? sses? when cut? sses? he first visit, what was the atment in the past? mouth, head or teeth? tion or shedding of teeth? City water	water Bottled water hen are the teeth brushed	sit? Date:				
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