

Name _____ Date _____

Health History

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had difficulty with previous dentists? _____

Has your child ever had any of the following:

- | | | | |
|------------|--|-------------------------|--|
| Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatic Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer | <input type="checkbox"/> YES <input type="checkbox"/> NO | Congenital Heart Defect | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hepatitis | <input type="checkbox"/> YES <input type="checkbox"/> NO | Handicaps/Disabilities | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HIV/AIDS | <input type="checkbox"/> YES <input type="checkbox"/> NO | Convulsions/Epilepsy | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hemophilia | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO | Abnormal Bleeding | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Allergies | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please explain any medical problems that your child has _____

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____

Phone Number _____

Child's Birthdate _____

Is your child's water fluoridated? YES NO

Does your child :

Suck thumb/finger YES NO

Suck/Bite lips YES NO

Bite/Chew nails YES NO

Chew hard objects (Pencils, etc.)... YES NO

Grind Teeth..... YES NO

Clench Jaws..... YES NO

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and /or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient or parent if minor

Date

*Schultz
Family
Dentistry*