



CHILD'S PERSONAL HISTORY

Child's First Name: _____ Child's Last Name: _____
Birthdate: _____ Age: _____ Sex: _____
City/State of Birth: _____ Reason for Today's Visit: _____
Names of Siblings: _____

FATHER-FIRST NAME: _____ LAST NAME: _____
Date of Birth: _____ Relationship to Child: _____
Home Address:(street) _____
(city) _____ (state) _____ (zip) _____
Telephone No: _____ Work No: _____
Social Security No: _____ Driver's License No: _____
Name & Address of Employer: _____
Job Title: _____
Dental Insurance Co: _____ Insurance Co 800 No: _____

MOTHER-FIRST NAME: _____ LAST NAME: _____
Date of Birth: _____ Relationship to Child: _____
Home Address:(street) _____
(city) _____ (state) _____ (zip) _____
Telephone No: _____ Work No: _____
Social Security No: _____ Driver's License No: _____
Name & Address of Employer: _____
Job Title: _____
Dental Insurance Co: _____ Insurance Co 800 No: _____

In case of a medical emergency, who may we contact, other than you:
Name: _____ Phone No: _____
Whom may we thank for referring you to this office? _____

MEDICAL HISTORY

These questions are of great value in aiding us in the treatment and better understanding your child, medically, dentally, and socially. Please circle YES or NO, and explain where needed.

1. Date of child's last **MEDICAL** exam: _____
2. Name of child's doctor/pediatrician: _____
3. Pediatrician's address & phone number: _____
4. Is your child taking any medicine now? (this includes vitamins, birth control pills, Tylenol, etc.)
List medicines: _____ YES NO
5. Has your child ever been hospitalized or had any operations? YES NO
Please explain: _____

6. Has your child ever received general anesthesia or sedation? YES NO
Please explain:_____
7. Are your child's immunizations up to date? YES NO
8. HAS YOUR CHILD BECOME SICK FROM, SHOWN AN ALLERGY TO, OR BEEN TOLD NOT TO TAKE:
(circle yes or no & EXPLAIN any yes answers)
- 8a. Foods_____ YES NO
- 8b. Penicillin, Amoxicillin, or other antibiotics_____ YES NO
- 8c. Aspirin, codeine, or other pain medication_____ YES NO
- 8d. Novocain, xylocaine, or other anesthetic_____ YES NO
- 8e. Other medicines_____ YES NO
- 8f. Latex rubber_____ YES NO
9. If your child has had a reaction to any of the items above, please explain what happens:

10. Has your child been exposed to the AIDS virus or is HIV positive? YES NO
11. Has you child ever had a blood transfusion? YES NO
12. Is your child a foster child? YES NO
13. Was this child's mother using alcohol, cocaine, or other drugs during pregnancy? YES NO
14. Has you child ever been abused or molested?
(this can effect a child's behavior in any setting) YES NO
15. Is there any family history of malignant hyperthermia? YES NO
16. DOES YOUR CHILD HAVE OR HAS EVER HAD:
(circle YES or NO, and circle the appropriate disease where necessary)
- 16a. Heart disease YES NO
- 16b. Heart murmur YES NO
- 16c. Heart defect from birth YES NO
- 16d. Rheumatic fever or disease YES NO
- 16e. High blood pressure YES NO
- 16f. Fainting spells, convulsions, epilepsy, recurrent headaches YES NO
- 16g. Mental deficiency, retardation, cerebral palsey YES NO
- 16h. Lung disease, asthma, bronchitis, TB YES NO
- 16i. Liver disease, jaundice, hepatitis YES NO
- 16j. Kidney disease YES NO
- 16k. Diabetes YES NO
- 16l. Hemophilia YES NO
- 16m. Blood disorders, anemia, sickle cell YES NO
- 16n. Arthritis YES NO
- 16o. Cancer, leukemia, tumors YES NO
- 16p. Measles, mumps, chickenpox YES NO
- 16q. Frequent sore throats, tonsillitis, ear aches YES NO
- 16r. Eye problems, blindness, cataracts YES NO
- 16s. Hearing problems, deafness YES NO
- 16t. Hyperactivity/learning problems, developmental delay YES NO

16u.	Hormonal, Endocrine problems	* YES	NO
16v.	Viral or Bacterial infections	YES	NO
16w.	Congenital birth defects (cleft lip, etc.)	YES	NO
16x.	Is your teenager sexually active?	YES	NO
16y.	Is your teenager pregnant?	YES	NO

DENTAL HISTORY

1. Date of child's last dental exam, cleaning, or x-rays: _____
2. Name of Previous Dentist: _____
3. How was your child's past dental experience: _____
4. Is your child CURRENTLY receiving fluoride in any form? YES NO
Please explain: _____
5. Has your child received fluoride in the past? YES NO
Please explain: _____
6. What age did your child stop breast feeding? _____ or bottle feeding? _____
7. Does your child suck his/her finger(s), thumb, pacifier, blanket, etc? YES NO
If yes, please explain: _____
8. Has there ever been any problems with your child's jaw joint (TMJ)? YES NO
9. Does your child clench or grind his/her teeth? YES NO
10. Please describe your child's personality or temperament: _____

11. When during the day or night are your child's teeth brushed? _____
Who does the brushing? _____
12. Is there anything else you think we should know about your child?

I certify that I have read and understood the above questions. I will not hold Dr. Allen or any member of her staff responsible for any errors or omissions I may have made in the completion of this form.

Signature: _____ Relation to child: _____

I hereby consent to the performance of Dental Services upon this patient. Services including exam, cleaning, fluoride, anesthetics, sedatives, fillings, or necessary x-rays as may be deemed necessary and advisable by the Doctor. Necessary treatment will be discussed with the parent or guardian. I ALSO AGREE TO BE FINANCIALLY RESPONSIBLE FOR ANY TREATMENT, WORK PERFORMED, OR MISSED APPOINTMENTS. PAYMENT IS EXPECTED AT THE TIME OF SERVICE. If I have dental insurance, I agree to be financially responsible for any percentage my insurance company does not cover. I also agree to pay finance charges on any balance due over ninety (90) days. I also agree to reimburse the dentist for reasonable attorney fees and costs incurred in the collection of my delinquent account, if necessary.

Signature of Parent/Guardian: _____

Date: _____