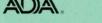


Child Health/Dental History Form



American Dental Association

						ww.ada.org	
Patient's Name	FIRST	INITIAL	Nickname		Date of Birth		
Parent's/Guardian's Name	Relationship to Patient						
Address							
PO OR MAILING ADD	DRESS		СІТУ		STATE	ZIP CODE	
Phone		Work			Sex M□ F		
Have you (the parent/guardian) or the patient had any of the following diseases or problems?							
Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.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	☐ HIV +/AIDS ☐ Mononucleosis ☐ Thyroid						
☐ Arthritis	☐ Cerebral Palsy	□ Fainting				☐ Tobacco/Drug	Jse
☐ Asthma☐ Bladder	☐ Chicken Pox☐ Chronic Sinusitis	☐ Growth Problems ☐ Hearing	☐ Kidney ☐ Latex allergy	☐ Pregna	ncy (teens)	☐ Tuberculosis☐ Venereal Diseas	0
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver ☐ Seizures			Other_	
☐ Bones/Joints	☐ Ear Aches	□ Hepatitis	□ Measles	□ Sickle		- 0.110.	
Please list the name and phone number of the child's physician:							
Name of PhysicianPhone							
Child's History							oe No
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:							
Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: Is the child allergic to anything else, such as certain foods? If yes, please explain:						3.	
4. How would you desc	ribe the child's eating hab	ts?					
5. Has the child ever had a serious illness? If yes, when: Please describe:						5.	
6. Has the child ever been hospitalized?							
7. Does the child have a history of any other illnesses? If yes, please list:						7.	
Has the child ever received a general anesthetic? Does the child have any inherited problems?							
10. Does the child have any speech difficulties?							
11. Has the child ever had a blood transfusion?							
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?						14.	0 0
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date:						15.	0 0
16. Has the child 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?							
19. Has the child had any problems with the eruption or shedding of teeth?						19.	
20. Has the child had any orthodontic treatment?							
22. Does the child take						22.	0 0
23. Is fluoride toothpas	ste used?					23.	
24. How many times are the child's teeth brushed per day? When are the teeth brushed?							
25. Does the child suck h							0 0
 At what age did the c Does child participate 							0 0
27. Does child participate in active recreational activities?							
satisfaction. I will not hold	my dentist, or any other m	ember of his/her staff, resp					
omissions that I may have made in the completion of this form.							
Parent's/Guardian's Signatu	ire			Date			
For completion by dentist							
Comments							
PERSONAL						U.C. LANCES	
Autobalian Carlon Fri				1000			THE REAL PROPERTY.
For Office Use Only: Medica	al Alert U Premedication U All	ergies 🗆 Anesthesia Reviewe	ad by				