PATIENT HEALTH RECORD FOR CHILDREN 12 AND UNDER

In order to help render proper dental services to you, please answer the following questions. There are two sides to be completed. PLEASE PRINT.

Date _____

Patient's Name _____
What do you prefer to be called?
_____

Address: Street _____

City _____

State _____ Zip _____

Date of Birth _____

Sex: M F Height _____ Weight _____

Family Physician _____

Home Phone Number _____
Name closest relative and relationship:
_____

_____

Whom may we thank for referring you?
_____

Name of Mother _____

Work Phone _____

Place of Employment _____

City _____

State _____ Zip _____

Name of Father _____

Work Phone _____

Place of Employment _____

City _____

State _____ Zip _____

OR:

Name of Guardian _____

Work Phone _____

Place of Employment _____

City _____

State _____ Zip _____

Do you have DENTAL insurance? YES NO
If yes, please complete the following:

Name of Insured _____

Name of Insurance Co. _____

Insured's SS # _____

Group # _____

(OVER)

Please circle the appropriate answer

1. Does your child have a health problem? . . . . . YES NO
2. Was your child a patient in a hospital? . . . . . YES NO
3. Date of last physical exam: _____
4. Is your child now under medical care? . . . . . YES NO
5. Is your child taking medication now? . . . . . YES NO
   If so, for what? _____
6. Has your child ever had a serious illness or operation? . . . . . YES NO
7. If so, explain: _____
8. Does your child have (or ever had) any of the following diseases?
   a. Rheumatic fever or rheumatic heart disease YES NO
   b. Congenital heart disease . . . . . YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis stroke) . . YES NO
   d. Allergy? Food ☐ Medicine ☐ Other ☐ YES NO
      Specify _____
   e. Asthma ☐ Hay Fever ☐ . . . . . YES NO
   f. Hives or a skin rash . . . . . YES NO
   g. Fainting spells or seizures . . . . . YES NO
   h. Hepatitis, jaundice or liver disease . . . . . YES NO
   i. Diabetes . . . . . YES NO
   j. Inflammatory rheumatism (painful or swollen joints) . . . . . YES NO
   k. Arthritis . . . . . YES NO
   l. Stomach ulcers . . . . . YES NO
   m. Kidney trouble . . . . . YES NO
   n. Tuberculosis (TB) . . . . . YES NO
   o. Persistent cough or cough up blood . . . . . YES NO
   p. Venereal disease . . . . . YES NO
   q. Epilepsy . . . . . YES NO
   r. Sickle Cell disease . . . . . YES NO
   s. Thyroid disease . . . . . YES NO
   t. AIDS . . . . . YES NO
   u. Emphysema . . . . . YES NO
   v. Psychiatric treatment . . . . . YES NO
   w. Cleft lip / palate . . . . . YES NO
   x. Cerebral palsy . . . . . YES NO
   y. Mental retardation . . . . . YES NO
   z. Hearing disability . . . . . YES NO
   aa. Development disability . . . . . YES NO
      If yes, please explain: _____
   bb. Was your child premature? . . . . . YES NO
      If yes, how many weeks _____
   cc. Other: _____
9. Does your child have to urinate (pass water) more than six times a day? . . . . . YES NO
10. Is your child thirsty much of the time? . . . . . YES NO
11. Has your child had abnormal bleeding associated with previous surgery, extractions or accidents? YES NO
12. Does he/she bruise easily? . . . . . YES NO
13. Has he/she ever required a blood transfusion? YES NO
14. Does he/she have any blood disorders such as anemia, etc.? . . . . . YES NO
15. Has he/she ever had surgery, x-ray or chemotherapy for a tumor, growth, or other condition? . . . . YES NO
16. Does your child have a disability that prevents treatment in a dental office? . . . . . YES NO
17. Is he/she taking any of the following?
   a. Antibiotics or sulfa drugs . . . . . YES NO
   b. Anticoagulants (blood thinners) . . . . . YES NO
   c. Medicine for high blood pressure . . . . . YES NO
   d. Cortisone or steroids . . . . . YES NO
   e. Tranquilizers . . . . . YES NO
   f. Aspirin . . . . . YES NO
   g. Dilantin or other anticonvulsant . . . . . YES NO
   h. Insulin, tolbutamide, Orinase, or similar drug YES NO
   i. Any other? _____
18. Is he/she allergic to, or has he/she ever reacted adversely to any of the following?
   a. Local anesthetics . . . . . YES NO
   b. Penicillin or other antibiotics . . . . . YES NO
   c. Sulfa drugs . . . . . YES NO
   d. Barbituates, sedatives, or sleeping pills . . YES NO
   e. Aspirin . . . . . YES NO
   f. Any other? _____
19. Has he/she had any serious trouble associated with any previous dental treatment? . . . . . YES NO
   If so, please explain: _____
20. Has your child been in any situation which could expose him/her to x-rays or other ionizing radiation? . . YES NO
21. Last date of dental examination: _____
22. Has he/she ever had orthodontic treatment (worn braces)? . . . . . YES NO
23. Has he/she ever been treated for any gum diseases (gingivitis, periodontitis, trenchmouth, pyorrhea)? YES NO
24. Does his/her gums bleed when brushing teeth? YES NO
25. Does he/she grind or clench teeth? . . . . . YES NO
26. Has he/she often had toothaches? . . . . . YES NO
27. Has he/she had frequent sores in his/her mouth? YES NO
28. Has he/she had any injuries to his/her mouth or jaws? . . . . . YES NO
   If yes, explain: _____
29. Does he/she have any sores or swellings on his/her mouth or jaws? . . . . . YES NO
30. Does he/she have frequent headaches? . . . . . YES NO
31. Have you been satisfied with your child's previous dental care? . . . . . YES NO
32. How often does he/she brush/floss? _____
33. What texture tooth brush does he/she use?
   SOFT MEDIUM HARD
34. Is he/she on home fluoride? . . . . . YES NO
35. Do you have fluoridated water where you live? YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/her medicines change, I will inform the doctor at the next appointment without fail.

Parent's Signature _____ Date _____