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DENTAL GROUP

CHILDREN'S HEALTH HISTORY FORM

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

Your child

Child's Name: _____
Last First MI

Nickname:_____ Sex:_____

Birth date:_____/_____/_____ Age:_____

Social Security #:_____

Child's Home Address:_____

_____
City State Zip

Phone #:( )_____

Person Responsible for Account:_____

Relationship:_____

Telephone #:_____

Mother Stepmother Guardian

Name:_____

E-Mail:_____

Home Phone #:_____

Work Phone #:_____

Social Security #:_____

Employer:_____

Occupation:_____

Father Stepfather Guardian

Name:_____

E-Mail:_____

Home Phone #:_____

Work Phone #:_____

Social Security #:_____

Employer:_____

Occupation:_____

Parent's Marital Status

☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Primary Dental Insurance

Insured's Name:_____

Relationship:_____

Birth Date:___/___/___ SS #:_____

Employer:_____ Date Employed:_____

Occupation:_____

Insurance Company:_____

Insurance Co Phone #:_____

Group #:_____ Emp. #:_____

Insurance Co. Address:_____

Ded:_____ Max Annual Benefit:_____

Orthodontic Coverage? ◉ Yes ○ No

Additional Insurance

Insured's Name:_____

Relationship:_____

Birth Date:___/___/___ SS #:_____

Employer:_____ Date Employed:_____

Occupation:_____

Insurance Company:_____

Insurance Company:_____

Insurance Co Phone #:_____

Group No:_____ Emp. #:_____

Insurance Co. Address:_____

Ded:_____ Max Annual Benefit:_____

Orthodontic Coverage? ☐ Yes ☐ No

Who is responsible for making appointments?

Name:_____

E-mail:_____

Relationship:_____

Home Phone #:_____

Work Phone #:_____

Best Time to Call: (Time)_____ Days:_____

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Medical History

Has your child had any difficulty with previous visits?_____

Comments:_____

Is Minor / Child taking any prescription / over the counter drugs?

☐ Yes ☐ No

Please list each one:_____

Ever been hospitalized?	☐ Yes	☐ No
Ever had Surgery?	☐ Yes	☐ No

Has you child ever had any of the following diseases or medical problems?

Asthma	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Drug / Alcohol Abuse	☐ Yes	☐ No
Handicaps / Disabilities	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No

Please explain any medical problems (including Allergies) that your child has: _____

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. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services for my minor / child.

_____

Date Signature

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:(_____)_____

Is your child's water fluoridated?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No

Does your child:

Suck Thumb / Fingers?	☐ 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

Dentist's Review

_____

_____

_____

Date:____/____/____ Signature:_____

Health History Update

Comments:_____

_____

_____

Date:____/____/____ Dr. Signature:_____

Comments:_____

_____

_____

Date:____/____/____ Dr. Signature:_____

Comments:_____

_____

_____

Date:____/____/____ Dr. Signature:_____

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How to prepare your child for his or her first dental visit

Sometimes, children hear negative things about visiting the dentist and worry about going for the first time. Here are some tips to help ease your child's nerves so that his or her first dental visit can be a pleasant experience:

• **Don't** prepare them by saying things like, "I know you are scared, but it won't hurt much," or "You will be in big trouble if you don't behave at the dentist." Phrases like these indicate that there will be some pain involved, or that going to the dentist will be a scary experience.

• **Don't** talk about negative experiences you have had at the dentist.

• Practice counting your child's teeth by placing a toothbrush on each tooth and counting each one. Tell your child that the dentist is going to count his or her teeth and then clean them. This will help them to know what to expect so that they can be more at ease before the visit.

• When you talk to your children about going to the dentist, act like it is **no big deal**. You can also tell them that they will get a prize after the visit so they have something to look forward to.

• If your child is still afraid of coming to the dentist, we can have the first appointment be a "happy visit". We will let them ride up and down in the dental chair, suck the water out of a cup with the suction, "Mr. Thirsty", and choose a prize at the end. This will make them much more relaxed when they come for their real visit.

Once your child feels confident about going to the dentist, every visit will be worry-free.