

## Children's Dental Center

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THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR  
ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD.

Patient's Name \_\_\_\_\_

Nickname \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Father's Name \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Beeper# \_\_\_\_\_

Where Employed \_\_\_\_\_ Position \_\_\_\_\_

How Long Held \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Beeper# \_\_\_\_\_

Where Employed \_\_\_\_\_ Position \_\_\_\_\_

How Long Held \_\_\_\_\_ Work Phone \_\_\_\_\_

Phone Number For Confirmation of Appointment \_\_\_\_\_

With whom does patient live? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

What relationship are you to this patient? \_\_\_\_\_

If you are not the parent, do you have legal guardianship through the  
court? Yes \_\_\_\_\_ No \_\_\_\_\_

## HEALTH HISTORY

Who is your child's medical doctor? \_\_\_\_\_

	Yes	No
Is your child in good health?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child up to date with immunizations?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child taking medication at this time?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what medication? _____		
Is your child allergic to any medication?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what medication? _____		
Is your child undergoing any type of medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what? _____		
Has your child been hospitalized since birth?	<input type="checkbox"/>	<input type="checkbox"/>
Date _____ Reason _____		
Has your child had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Date _____ Place _____		
Does your child drink tap water?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child Drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have your own transportation to our office?	<input type="checkbox"/>	<input type="checkbox"/>
Do you require medical transportation to our office?	<input type="checkbox"/>	<input type="checkbox"/>

**Check only the following that may pertain to your child**

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Condition or Heart Murmur | <input type="checkbox"/> Hemophilia              |
| <input type="checkbox"/> Lung Problem                    | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Brain Injury                    | <input type="checkbox"/> Asthma/Bronchitis       |
| <input type="checkbox"/> Liver Problem                   | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> Kidney Problem                  | <input type="checkbox"/> Retardation             |
| <input type="checkbox"/> Epilepsy                        | <input type="checkbox"/> Mental Disorder         |
| <input type="checkbox"/> Seizures                        | <input type="checkbox"/> Emotional Disorder      |
| <input type="checkbox"/> Convulsions                     | <input type="checkbox"/> Autism                  |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Speech Disorder         |
| <input type="checkbox"/> Cerebral Palsy                  | <input type="checkbox"/> Speech Therapy          |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Hearing Disorder (Deaf) |
| <input type="checkbox"/> Hepatitis                       | <input type="checkbox"/> Vision Disorder (Blind) |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Slow Learner            |
| <input type="checkbox"/> Radiation or chemotherapy       | <input type="checkbox"/> ADD / ADHD              |
|  | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> None of the above mentioned     |  |

	Yes	No
Is this your child's first visit to a dentist?	<input type="checkbox"/>	<input type="checkbox"/>
If not, date of last dental visit _____		
Is your child nervous about today's visit?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had an unfavorable experience in a dental office?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have a toothache?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child a finger or thumbsucker?	<input type="checkbox"/>	<input type="checkbox"/>
Does or did your child use a pacifier?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child bottle-fed?	<input type="checkbox"/>	<input type="checkbox"/>
Until what age? _____		
Was your child breast-fed?	<input type="checkbox"/>	<input type="checkbox"/>
Until what age? _____		

Purpose of this appointment \_\_\_\_\_

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment. \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Is your child covered under the Texas Medicaid Program?

Do you have Dental Insurance? \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Carrier \_\_\_\_\_

Name of Insured \_\_\_\_\_

I agree to diagnostic procedures and dental treatment and patient management techniques as found necessary and desirable for the patient named above. I authorize release of the information to the patient's medical doctor of record .

Date \_\_\_\_\_

Signature of person legally responsible

Dental Assistant reviewing history