Today's Date _____

Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information that we create, receive or maintain. Your answers are for our records and will be kept confidental subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient's Name _____ Date of Birth _____ Age _____ Sex _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ If a child, both parents' names _____

Spouse's name _____ Person responsible for account _____

Please fill out on yourself (If a child, please fill out both parents)	**Please fill out on spouse**
NAME _____	**NAME** _____
Employer _____	Employer _____
Position _____	Position _____
Business Phone _____	Business Phone _____
Dental Insurance name _____	Dental Insurance name _____
Group or Employee No. _____	Group of Employee No. _____
Social Sec. No. _____	Social Sec. No. _____
Birthdate _____	Birthdate _____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you? _____ Phone # _____

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... ❑ Yes ❑ No

1. 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	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex Allergy	❑ Rheumatic Fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other _____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____ _____

Child's History

		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: _____	1. ❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. ❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. ❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. ❑	❑
6.	Has the child ever been hospitalized?	6. ❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	7. ❑	❑
8.	Has the child ever received a general anesthetic?	8. ❑	❑
9.	Does the child have any inherited problems?	9. ❑	❑
10.	Does the child have any speech difficulties?	10. ❑	❑
11.	Has the child ever had a blood transfusion?	11. ❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	12. ❑	❑
13.	Does the child experience excessive bleeding when cut?	13. ❑	❑
14.	Is the child currently being treated for any illnesses?	14. ❑	❑
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. ❑	❑
16.	Has the child had any problem with dental treatment in the past?	16. ❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	17. ❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	18. ❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	19. ❑	❑
20.	Has the child had any orthodontic treatment?	20. ❑	❑
21.	**What type of water does your child drink?** ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
22.	**Does the child take fluoride supplements?**	22. ❑	❑
23.	**Is fluoride toothpaste used?**	23. ❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. ❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	25. ❑	❑
26.	Does child participate in active recreational activties?	26. ❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's/Guardian's Signature _____ Date _____ _____

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