Child's Health History

Child's Name _____ Nickname_____ Age_____ Sex: F M

Date of Birth _____ Place of Birth _____

Health History

Child's Physician _____ Date of Last Physical Exam _____

Physician Phone _____

	Yes	No
Is your child under the care of a Physician now? _____	[ ]	[ ]
Is your child receiving medication or drugs? _____	[ ]	[ ]
If YES, name of Medication _____		
Amount Given _____ How often? _____		
Purpose of Medication _____		
Is there any excessive bleeding when cut or		
does your child bruise easily? _____	[ ]	[ ]
Has your child ever been hospitalized or had		
surgery? If YES, explain _____	[ ]	[ ]
Is there any allergy to penicillin or other drugs? _____	[ ]	[ ]
If YES, list _____	[ ]	[ ]
Has your child been diagnosed with an Autism Spectrum		
Disorder, such as Asperger's Syndrome or Autism?_____	[ ]	[ ]

	Yes	No
Does your child have Asthma? _____	[ ]	[ ]
Are there other allergies? _____	[ ]	[ ]
Food Pollen Animals Dust Latex		
Is your child taking any medications for emotional		
problems or ADHD? _____	[ ]	[ ]
Any problems with liver, kidney, or heart? _____	[ ]	[ ]
Any problems with heart murmurs, congenital		
heart disorders? _____	[ ]	[ ]
Has your child had rheumatic fever? _____	[ ]	[ ]
Does your child have diabetes? _____	[ ]	[ ]
Any fainting spells, convulsions or seizures? _____	[ ]	[ ]
Is there **any** other medical or health problem which		
your child has that is not listed on this form? __	[ ]	[ ]
If YES, explain _____		

Dental Information

Previous Dentist (if any) _____ Date of Last Visit _____ Family Dentist _____

	Yes	No
Has your child complained about dental problems? _____	[ ]	[ ]
Has your child had any unhappy dental experiences?_____	[ ]	[ ]
Any habits? (Please circle) Thumb Sucking Nail Biting		
Mouth Breathing Tooth Grinding		
May we have your consent to use photographs of your child		
in articles we may publish in dental journals? _____	[ ]	[ ]
May we have your consent to use photographs of your child		
on social media (Facebook, Google+, website)?	[ ]	[ ]
Is your child currently in orthodontic treatment? _____	[ ]	[ ]
Name of Orthodontist _____		

	Yes	No
Does your child brush his/her teeth daily? _____	[ ]	[ ]
Do you assist child with tooth brushing? _____	[ ]	[ ]
Is dental floss used daily? _____	[ ]	[ ]
Is Fluoride taken in any form? (Circle those used)		
Liquid Tablets Toothpaste Mouth Rinse		
May we have your consent to use a local anesthetic		
and/or nitrous oxide/oxygen (laughing gas) for		
necessary dental treatments? _____	[ ]	[ ]

Mother: Condition of Teeth _____ Gums _____ Use Floss? _____

Father: Condition of Teeth _____ Gums _____ Use Floss? _____

Other Children: Condition of Teeth _____ Gums _____ Use Floss? _____

Your child's favorite toy and TV program/DVD/video game_____

I give authorization and consent to dental examination and any dental treatment of the above named minor child to be rendered to said minor child under the general or direct supervision of Toshi Hart, D.D.S. and/or her Associates. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent and/or Legal Guardian _____ Date _____

UPDATES:

Date _____ Changes in Health / **NO** Changes in Health (please circle) Initials _____

Date _____ Changes in Health / **NO** Changes in Health (please circle) Initials _____