Child Health History

Patient Name: _____ Parent's Phone #: Cell_____Home_____

Work _____

Date of Birth:_____Gender: M F Parent's Email Address:_____

Patient's Address: _____

Parent / Guardian Name:_____

Parent /Guardian Address: _____

Name of Child's Physician: _____ Physician's Phone #:_____

--WHO IS WITH THE CHILD TODAY:

Name:_____ Relation:_____

Do you have custody of this child: Yes No

Who may we thank for referring you?_____Other family members seen by us:_____

Previous/Present Dentist:_____

Parent's Marital Status: Single Married Divorced

--PRIMARY DENTAL INSURANCE:

Insurance Name:_____ Ins. Company Phone #:_____

Insurance Company Address: _____

Group Policy Number:_____ Insured's Name:_____

Relationship to Patient:_____Insured's DOB: _____

Insured's Employer:_____ Orthodontic Coverage: Yes No

Social Security Number:_____

THE REASON FOR TODAY'S APPOINTMENT:

What does concern you or your child about his or her teeth:_____

Has the child ever had a serious/difficult problem associated with dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in the jaw joint (TMD/TMJ)? Yes No

Does the child brush teeth daily? Yes No

Does the child floss his or her teeth daily? Yes No

A) **PLEASE CIRCLE APPROPRIATE ANSWER** (Leave blank if you do not understand the question):

1. Yes No Is your child's general health good?
2. Yes No Was your child born prematurely? If YES, How many weeks?_____
3. Yes No Has your child been hospitalized or had surgery?
   If Yes, explain_____
4. Yes No Is your child being treated by a physician now? Date of last medical exam:_____
   If YES, for What?_____
5. Yes No Does your child take any medicine/medications? (e.g. Prescription/Over the counter/herbal)
   If YES, what?_____

6. Yes No Does your child have any allergies to drugs, food, other (e.g. LATEX)?
If YES, Please explain type/severity of reaction?_____

7. Yes No Has your child had problems with prior dental treatment? Date of Last dental exam:_____
If YES, Please explain:_____

8. Yes No Is your child in pain now or having a problem with his or her teeth?_____

B) DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD:

9.	Yes	No	Asthma or trouble breathing?	20.	Yes	No	High blood pressure?
10.	Yes	No	Ear aches or ear problems?	21.	Yes	No	Cystic fibrosis?
11.	Yes	No	Hearing problems?	22.	Yes	No	Ulcers or stomach problems?
12.	Yes	No	Eye problems?	23.	Yes	No	Eating disorder/unusual diet?
13.	Yes	No	Speech problems?	24.	Yes	No	Hepatitis, jaundice, liver disease?
14.	Yes	No	Sinus problems?	25.	Yes	No	Extreme Weight Loss or gain?
15.	Yes	No	Cleft lip/cleft palate?	26.	Yes	No	Prolonged diarrhea?
16.	Yes	No	Apnea/Snoring?	27.	Yes	No	Bladder or kidney problems?
17.	Yes	No	Heart murmur or other heart problems?	28.	Yes	No	Arthritis or joint problems?
18.	Yes	No	Rheumatic fever or rheumatic heart disease?	29.	Yes	No	TMJ OR jaw joint problems?
19.	Yes	No	Skin problems?(e.g. eczema, hives, impetigo)	30.	Yes	No	Scoliosis or spine problems?

C) DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD:

31.	Yes	No	Fainting or dizziness?	38.	Yes	No	Psychiatric treatment?
32.	Yes	No	Autism?	39.	Yes	No	Diabetes/high blood pressure?
33.	Yes	No	developmental delays or growth delays?	40.	Yes	No	Thyroid Problems?
34.	Yes	No	Learning disorders?	41.	Yes	No	Anemia
35.	Yes	No	Attention deficit/hyperactivity disorder(ADHD)?	42.	Yes	No	Blood disorder or transfusion?
36.	Yes	No	Mental problems or behavior disorders?	43.	Yes	No	Excessive bleeding/hemophilia?
37.	Yes	No	Brain and head injury?	44.	Yes	No	Sickle Cell disease or trait?

D) DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD:

45.	Yes	No	Cerebral palsy?	50.	Yes	No	Cancer or tumor?
46.	Yes	No	Epilepsy, convulsions or seizures?	51.	Yes	No	Immune Disorder?
47.	Yes	No	Headaches or migraines?	52.	Yes	No	Chemotherapy ?
48.	Yes	No	Hydrocephaly or shunts?	53.	Yes	No	HIV/AIDS?
49.	Yes	No	Radiation treatment? Please list to what parts of the body and when _____				

E) DOES YOUR CHILD OR HAS YOUR CHILD:

54.	Yes	No	Smoke tobacco	56.	Yes	No	Use recreational drugs?
55.	Yes	No	Chew tobacco	57.	Yes	No	Use Alcohol?

F) FEMALE (TEENS) ONLY:

58.	Yes	No	Is your child taking birth control pills?	59.	Yes	No	Could your child be pregnant?

H) ALL PATIENTS:

60. Yes No Does your child have or has your child had any other diseases, medical problems NOT listed on this form?
If YES, please explain:_____

61. Yes No Does your child play organized sports?
If YES, please explain:_____

62. Yes No Does your child wear a helmet or mouthguard when playing either recreational or organized sports?
If YES, please explain:_____

—To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Hanachi's offic of any change in my child's health and/or medication.

—I also authorize Dr. Hanachi's staff to perform the necessary dental services my child may need.

Parent or Guardian's signature:_____ Date:_____

Relationship to the Patient:_____