NEW PATIENT CHILD HEALTH HISTORY FORM

Date: 08/10/2017

Last Name: First Name: Birthdate:

Parent's/Guardians Name: Parent's Phone:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential 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.

Dental Information

(For the following questions, please mark(X) your responses to the follwing questions.)

	Y	N
Is this the Rosalia's first visit to a dentist?	☐	☐
If not the first visit, what was the date of child last dentist visit:		
Has Rosalia ever had dental radiographs (x - rays) exposed?	☐	☐
If yes, what was the date of child last radiographs esposed?		
What is the reason for your dental visit today?		
Has Rosalia had any problems associated with previous dental treatment? ______	☐	☐
Has Rosalia ever suffered any injuries to the head or mouth, or teeth? ______	☐	☐
Has Rosalia had any problems with the eruption or shedding of teeth? ______	☐	☐
Has Rosalia ever had orthodontic (braces) treatment? ______	☐	☐
How many times are the child's teeth brushed per day?		
When are the teeth brushed?		
Does Rosalia suck his/her thumb, fingers or pacifier? ______	☐	☐
At what age did the child stop bottle feeding? Age		
At what age did the child stop breast feeding? Age		
Does Rosalia participate in active recreational activities? ______	☐	☐
What type of water does your child drink?		
☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
Does Rosalia take fluoride supplements? ______	☐	☐
Does Rosalia use fuoride toothpaste? ______	☐	☐

Medical Information

(Please mark(X) your response to indicate if you have or have not had any of the following diseases or problems.)

	Y	N
Are Rosalia Ferreira Teixeira under the care of a physician?	☐	☐

Physician Name: Physician Phone:

Address/City/State:

	Y	N
Are Rosalia Ferreira Teixeira in good heal	☐	☐
Has there been any change in child general health within the past year?	☐	☐
If yes, what condition is being treated?		
Date of last physical exam:		
Has the child had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
If yes, what was the illness or problems?		
Is the child taking or has the child recently taken any prescription or over the counter medicine(s)?	☐	☐

If yes, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Allergies.

Is the child allergic to or has she/he had a reaction to:

Y	N		Y	N	
☐	☐	Local anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex (rubber)
☐	☐	Codeine or othernarcotics	☐	☐	Penicillin or other antibiotics
☐	☐	Ibuprofen	☐	☐	Seasonal
☐	☐	Barbiturantes, sedatives, or sleeping pills	☐	☐	Food
☐	☐	Sulfa drugs	☐	☐	Other

(To all yes responses, specify type of reaction.)

	Y	N
Do the child wear contact lenses?	☐	☐

Health Problems

(Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.)

Y N

Have you (the parent/guardian) or the patient had any of the following diseases or problems?
1- Active Tuberculosis
2- Persistent cough greater than a three-week duration
3- Cough that produces blood? ☐ ☐

If you answered yes to any of the three items above, please stop and return this form to the receptionist.

How do you describe the child's eating habits?

Has the child ever had a serious illness? ________ ☐ ☐

If yes, When: Please describe:

Has the child ever been hospitalized? ________ ☐ ☐

Does the child have a history of any other illnesses? ________ ☐ ☐

If yes, please list:

Has the child ever received a general anesthetic? ________ ☐ ☐

Does the child have any inherited problems? ________ ☐ ☐

Does the child have any speech difficulties? ________ ☐ ☐

Has the child ever had a blood transfusion? ________ ☐ ☐

Is Rosalia physically, mentally, or emotionally impaired? ________ ☐ ☐

Does the child experience excessive bleeding when cut? ________ ☐ ☐

Is Rosalia currently being treated for any illnesses? ________ ☐ ☐

Has the child had any history of , or conditions related to, any of the following:

Y N
☐ ☐ Cardiovascular disease
☐ ☐ Congestive heart failure
☐ ☐ Other congenital heart defects (specify)
☐ ☐ Rheumatic Fever
☐ ☐ Bleeding disorder
☐ ☐ Anemia
☐ ☐ Blood transfusion (if yes,date)
☐ ☐ Hemophilia

Y N
☐ ☐ Arthritis
☐ ☐ Asthma
☐ ☐ Tuberculosis
☐ ☐ Diabetes
☐ ☐ Thyroid problems
☐ ☐ Epilepsy
☐ ☐ Hepatitis
☐ ☐ Liver disease
☐ ☐ AIDS or HIV infection
☐ ☐ Kidney problems

Y	N		Y	N	
☐	☐	Autoimmune disease	☐	☐	Neurological disorders (if yes, specify)
☐	☐	Bronchitis			
☐	☐	Emphysema	☐	☐	Mental health disorders (specify)
☐	☐	Chronic Sinusitis			
☐	☐	Cancer/Chemotherapy/Radiation treatment	☐	☐	Recurrent infections (type of infection:)
☐	☐	Fainting			
☐	☐	Seizures	☐	☐	Malnutrition
☐	☐	Bladder problems?	☐	☐	Bones/Joints
☐	☐	Cerebral Palsy	☐	☐	Chicken Pox
☐	☐	Eating disorder	☐	☐	Gastrointestinal disease
☐	☐	Ear Aches	☐	☐	Hearing problems?
☐	☐	Growth problems?	☐	☐	Measles
☐	☐	Mononucleosis	☐	☐	Momps
☐	☐	Sickle cell	☐	☐	Tobacco/Drug Use
☐	☐	Pregnancy (teens)	☐	☐	Sexually transmitted disease

☐ ☐ Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain:

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 understand the above and that the information given on this form is accurate. I understand the importance of an honest health history and that my dentist and his/her staff will rely on this information for my treatement. I acknowledge that my questions, if any, about inquiries set forth will be 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.

Signature of Patient/Legal Guardian

Signature of Dentist