

MINOR'S INFORMATION AND HEALTH HISTORY

MINOR'S NAME _____ NICKNAME _____ AGE _____ DATE OF BIRTH _____

SCHOOL _____ GRADE _____

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____ MOTHER'S NAME _____

FATHER EMPLOYED BY _____ HOW LONG _____ HOME PHONE _____ BUS PHONE _____

MOTHER EMPLOYED BY _____ HOW LONG _____ HOME PHONE _____ BUS PHONE _____

PERSON FINANCIALLY RESPONSIBLE _____ RELATIONSHIP TO CHILD _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

FATHER'S SOCIAL SECURITY NUMBER _____ MOTHER'S SOCIAL SECURITY NUMBER _____

NAME OF DENTAL INSURANCE COMPANY _____

WHOM MAY WE THANK FOR REFERRING YOU _____

PURPOSE OF CALL: REGULAR CHECKUP SPECIFIC PROBLEM

DENTAL HISTORY

NAME OF PREVIOUS DENTIST _____ CITY OR TOWN _____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE: YES NO EXPLAIN _____

DOES YOUR CHILD HAVE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- | | | |
|--|--|--|
| <input type="checkbox"/> Traumatic injury to mouth or teeth | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Texture of toothbrush _____ |
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure | <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Frequency of brushing _____ |
| <input type="checkbox"/> Bleeding gums. How long _____ | <input type="checkbox"/> Home fluoride treatment or rinses | <input type="checkbox"/> Dental floss |
| <input type="checkbox"/> Food impaction | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Fluoride supplements |
| <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Vitamins with fluoride |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Oral habits, i.e., thumb sucking, fingernail biting, cheek biting, etc. | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Frequent blisters on lips or mouth | | |

MEDICAL HISTORY

PHYSICIAN'S NAME _____ TOWN _____ TELEPHONE NO. _____ DATE OF LAST MEDICAL EXAM. _____

DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergy to penicillin | <input type="checkbox"/> Hay fever or allergies in general | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Allergies to other drugs _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Physical or mental handicap |
| <input type="checkbox"/> Allergies to anesthetics or novacaine | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Any heart ailments or heart murmur | <input type="checkbox"/> Liver problems or hepatitis | <input type="checkbox"/> Eye disorders |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Malignancies or leukemia | <input type="checkbox"/> Hormonal or menstrual problems |
| <input type="checkbox"/> Excessive bleeding from cut or extraction | <input type="checkbox"/> Psychiatric care/emotional problems | <input type="checkbox"/> Ulcer or colitis |
| <input type="checkbox"/> Anemia or blood problems | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Extreme nervousness or apprehension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting spells or seizures | <input type="checkbox"/> Artificial joints or prostheses |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV positive |
| | | <input type="checkbox"/> Radiation treatments |

Taking any medications now? If so, what? _____

For how long? _____

Hospitalized or serious illness in last 5 years. _____

Describe any medical treatment including drugs taken, if not listed above _____

SIGNATURE _____ DATE _____

PARENT OR GUARDIAN

REVIEWED BY _____ UPDATES: _____