CHILD HEALTH HISTORY

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DATE _____

Chart #

Name _____ Birthday _____ Sex___

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

Father's Name _____ Father's S.S. # _____

Father Employed By _____ Business Phone _____

Business Address _____

Present Position Held _____

Mother's Name _____ Mother's S.S. # _____

Mother Employed By _____ Business Phone _____

Business Address _____

Present Position Held _____

Are You Covered By Dental Insurance? Yes _____ No _____ Name of Company _____

(It is necessary that you provide complete claim forms for all services that may be eligible for insurance coverage)

Whom may we thank for referring you? _____

Physician's Name _____ Phone No. _____

PERSON RESPONSIBLE FOR ACCOUNT _____

Reason for seeking treatment _____

Medical History

YES___ NO___ 1. Are you now seeing or have you seen a physician in the past 5 years?

YES___ NO___ 2. Are you taking any medication or drugs? If yes, please list or describe _____

YES___ NO___ 3. Do you have any allergies to foods or drugs?
If yes, please enter foods or drugs _____

YES___ NO___ 4. Have you had any serious injuries or operations?
a. If yes, please describe _____

5. Circle any of the following diseases you have had:

a. Rheumatic fever
b. Scarlet fever
c. Tuberculosis
d. Congestive heart disease
e. Venereal disease
f. Heart attack (MI)
g. Heart murmur
h. Emphysema
i. Asthma
j. Congestive pulmonary disease
k. Hepatitis
l. Previous transfusions
m. Jaundice
n. Bleeding problems
o. Kidney infections
p. Diabetes
q. Mitral Valve Prolapse
r. HIV Virus

TREATMENT RECORD: PARENT'S SIGNATURE: _____

Date	Tooth No.	Surface	Procedure	Deb.	Cre.	Bal.