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HEALTH HISTORY

Why has your child come to the dentist today? _____

We believe that to best serve your child's dental health, we must understand your child in the larger context of his/her social and medical history. Please help us by thoughtfully answering the following questions. Please note that all health histories are held in strict confidence among our team. Complete both pages of the form.

_____ M / F _____
 Child's Name (Last, First) Child's Nickname Date of Birth Weight
 Child's Physician _____ Phone _____ Family Dentist _____
 Physician's Address _____

Is the child under care for any medical conditions? (Y / N) Medical diagnosis? _____
 Immunizations up to date? (Y / N / Unsure) Medication taken by child? _____
 Has child ever spend the night in a hospital? Explain: _____

ALLERGIES: Latex (Y / N) Metal (Y / N) Foods: _____
 Medications: _____
 Reaction to above allergies: _____

Has your child ever had or been diagnosed with any of the following?

- | | | | |
|-----|----------------------------------|-----|------------------------------------|
| (Y) | (N) | (Y) | (N) |
| ___ | ___ Anemia | ___ | ___ Aids/HIV |
| ___ | ___ Blood Disease | ___ | ___ Cancer or Malignancy |
| ___ | ___ Blood Transfusions | ___ | ___ Chronic Illness |
| ___ | ___ Bruises Easily | ___ | ___ Diabetes |
| ___ | ___ Hemophilia | ___ | ___ Epilepsy |
| ___ | ___ Sickle Cell Trait or Disease | ___ | ___ Hepatitis/Liver Disease |
| ___ | ___ Kidney Disease | ___ | ___ Transplant _____ |
| (Y) | (N) | (Y) | (N) |
| ___ | ___ Asthma | ___ | ___ Birth Defects |
| ___ | ___ Respiratory Problems | ___ | ___ Child Abuse |
| ___ | ___ Disease/RSV | ___ | ___ Concussion |
| ___ | ___ Heart Surgery | ___ | ___ Growth Problems |
| ___ | ___ Heart Murmur/Defect | ___ | ___ Premature Birth |
| ___ | ___ High Blood Pressure | ___ | ___ Surgery _____ |
| ___ | ___ Rheumatic Fever | ___ | ___ Syndrome _____ |
| (Y) | (N) | (Y) | (N) |
| ___ | ___ Arthritis | ___ | ___ Brain Injury |
| ___ | ___ Bone/Joint Problem TMJ | ___ | ___ Developmental Delays |
| ___ | ___ Headaches | ___ | ___ Hearing and/or Speech Problems |
| ___ | ___ Metabolic Disorder | ___ | ___ Hyperactivity/ADD/ADHD |
| ___ | ___ Muscle Disorder | ___ | ___ Neurological Disorder |

Dentist's Notes
 Health History
 Reviewed
 No Concerns
 Medical Alert
 Allergy

 PreMed

 Call MD

 Doctor's Initials _____

Are there any other conditions we need to know? _____
 Has your child ever had traumatic injury to the head? _____
 Has your child ever had traumatic injury to the teeth? _____

FAMILY HISTORY—PLEASE PRINT

Parent or Guardian _____
Parent SSN _____ Parent DOB _____
Street Address _____
City, State, Zip _____
Email Address _____
Home Phone _____ Cell Phone _____ Work Phone _____

Has your child been to the dentist? Y / N Date of visit _____
Dentist's Name _____
How did you hear about our office? _____
Name of person to contact in case of emergency _____
Relationship _____ Phone _____

INSURANCE

Insurance Company: Phoenix Health Health Choice Other _____

Member's Number _____

Siblings of Patient

Name	DOB
_____	_____
_____	_____
_____	_____

CONSENT

It is necessary because your child is a minor that permission is obtained from a parent or guardian before necessary treatment is performed. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate there to.

Initial

This consent shall remain in full force and in effect until cancelled by either party. I also consent to the use of agreed upon x-rays, study models, photographs, or any other diagnostic aids taken to be used for educational purposes. I fully understand this consent and have no further questions.

Initial

I give the doctors and staff at Kids Little Smiles permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays), prophylaxis, fluoride treatment and other diagnostic aids.

Initial

I have given an accurate report of my child's physical and mental health history. I have reported any prior allergic/unusual reactions, abnormal bleeding and other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Initial

Signature

Date