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# PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

This confidential information is of great value in aiding us to better understand and treat your child.

**REASON FOR VIST**_____ **Date**_____

Child's Name_____ Pref.Name_____ SEX M F

Age_____ Date of Birth_____ School _____ Grade _____

Name & Age of Brothers & Sisters _____

Kind & Name of any pet(s) _____

What is your child most interested in? _____

Child's Physician_____ Phone Number _____

City_____ Date last seen _____

Family Dentist_____ City _____

| | **HISTORY** | **CIRCLE** | |
|---|---|---|---|
| 1. | Is your child being treated by a physician at this time? ..... | YES | NO |
| | If yes, Why? _____ | | |
| 2. | Has your child ever been hospitalized or had surgery? …….. | YES | NO |
| | If yes, Why? _____ | | |
| 3. | Has your child ever received general anesthesia or sedation? …… | YES | NO |
| | If yes, why, and when? _____ | | |
| 4. | Is your child allergic to anything? (Medicine / Food /Latex) ……... | YES | NO |
| | If yes, what? _____ | | |
| 5. | Is your child taking any medications at this time? ……... | YES | NO |
| | If yes, medicine and dosage _____ | | |
| 6. | Has your child ever had a blood transfusion? …….. | YES | NO |
| 7. | Does your child have any blood disorders (anemia, etc.)? …… | YES | NO |
| 8. | Is your child subject to any nervous disorders, fainting or dizziness? …… | YES | NO |
| 9. | Does your child bruise easily? …… | YES | NO |
| 10. | Has your child a history of heart trouble, murmurs or rheumatic fever? …….. | YES | NO |
| 11. | Has your child a history of asthma? …….. | YES | NO |
| 12. | Has your child a history of diabetes? …… | YES | NO |
| 13. | Does your child have a handicapped problem or learning disabilities? ……... | YES | NO |
| 14. | Is this your child's first dental visit? …… | YES | NO |
| | Previous dentist _____ City _____ Last seen _____ | | |
| 15. | Has your child had an unfavorable experience in a previous dental / medical office? ……... | YES | NO |
| | How do you think he/she will act toward the dentist? _____ | | |
| 16. | At what age did your child stop bottle/breast feeding? _____ | | |
| 17. | Have there been any injuries to your child's teeth or jaws? (falls, blows, chips, etc.) …… | YES | NO |
| 18. | Is your child taking a fluoride supplement or drinking fluoridated water? …… | YES | NO |
| 19. | Does you child suck his/her thumb or fingers? ……... | YES | NO |
| 20. | How often does your child brush his/her teeth? _____ | | |
| 21. | What type of toothpaste does your child use? _____ | | |
| 22. | Is dental floss used? …… | YES | NO |
| 23. | Does your child have a problem with his/her bite or position of any teeth? …… | YES | NO |
| 24. | Is there any history of missing or extra teeth in the family? ……... | YES | NO |
| 25. | Has your child been seen by an orthodontist? …… | YES | NO |
| 26. | Has your child had any sores or swellings of his/her mouth or jaws? …….. | YES | NO |
| 27. | Has your child had frequent sores in his/her mouth? …… | YES | NO |
| 28. | Has your child ever had dental radiographs (X-rays) made? …… | YES | NO |
| | If yes, when? _____ | | |
| 29. | Have you been satisfied with your child's previous dental care? …….. | YES | NO |
| | If no, why? _____ | | |
| 30. | Is your child adopted? …….. | YES | NO |
| | Does your child know? …… | YES | NO |
| 31. | Who referred you to our office? _____ | | |
| 32. | Is there anything else we should know about your child? _____ | | |
| | _____ | | |

**>>>>>>>>>>PLEASE COMPLETE REVERSE SIDE ALSO<<<<<<<<<<**

**ORGANS AND SYSTEMS**

Has this child had any treatment for any of the following? Please circle all that apply:

| | | | |
|---|---|---|---|
| Blood – Circulatory | Eye | Liver | Respiratory – Lungs |
| Bones | Gastrointestinal – Stomach | Muscles | Skin |
| Endocrine Glands | Kidney – Bladder | Nervous System | Tonsils / Adenoids |
| Ears | Heart | Nose / Throat | |

**ILLNESS**

Has the child ever been diagnosed as having any of the following conditions? Please circle all that apply:

| | | | |
|---|---|---|---|
| Anemia | Diphtheria | Measles | Sickle Cell Anemia |
| Allergy | Drug or Alcohol Abuse | Mental Retardation | Sinus Problems |
| Arthritis | Emphysema | Mumps | Skin Rash / Hives |
| Asthma / Hay fever | Epilepsy | Mouth Breathing | Snoring At Night |
| Autism | Eye Problems | Nutritional Deficiency | Spina Bifida |
| Brain Injury | Excessive Bleeding Problem | Orthopedic Problems | Syndrome _____ |
| Bronchitis | Fainting | Pregnancy / Pregnant | Tetanus |
| Cancer | Hearing loss | Pneumonia | Thyroid Disease |
| Cerebral Palsy | Heart Disease | Polio | Tuberculosis |
| Chicken Pox | Hemophilia | Premature Birth | Venereal Disease |
| Cleft Lip / Palate | Hepatitis – Type_____ | Psychiatric Disorder | Whooping Cough |
| Convulsions / Seizures | AIDS | Rheumatic Fever | Other _____ |
| Developmental Disabilities | Jaundice | Scarlet Fever | _____ |
| Diabetes | Leukemia | Scoliosis | _____ |

**FAMILY INFORMATION**

Residential Address of Patient_____ City_____ Zip_____

Parent 1 _____ Phone _____ Birthdate _____
Residential Address _____ City_____ Zip _____
Employer _____ Occupation _____ Phone _____
Business Address _____ City _____ Zip _____

Parent 2 _____ Phone _____ Birthdate _____
Residential Address _____ City_____ Zip _____
Employer _____ Occupation _____ Phone _____
Business Address _____ City _____ Zip _____

**FINANCIAL RESPONSIBILITY**

Person responsible for child's financial support_____ Phone _____ Birthdate _____
Residential Address _____ City_____ Zip _____
Social Security No. _____ Drivers License No. _____
Employer _____ Occupation _____ Phone _____
Business Address _____ City _____ Zip _____

**INSURANCE INFORMATION**

Is your child covered by a dental insurance plan? …… YES NO

Name of Insurance Company _____ Group / Policy No. _____
Name of the Insured Parent _____ Social Security No. _____

**If in Military please give: Parents Pay Grade**_____ **Commanding Officer:** _____

**AUTHORIZATION**

I here by authorize Dr. Lauren L. Gutenberg and/ or her associates to perform any and all treatment for my above named child, and consent to such methods, drugs, and agents as may be indicated in connection with his / her dental care. This consent shall remain in effect until cancelled.

**Signature** _____ **Date** _____
Relationship to child _____

**PLEASE NOTE**: **Payment is expected for services rendered at the time of the first visit**. Financial arrangements for subsequent treatment may be made following the diagnosis. THANK YOU