EXTON DENTAL HEALTH GROUP CHILDREN'S HEALTH HISTORY FORM

Your child's overall health as well as any medications that your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Your child

Child's Name: _____
Last First MI

Nickname_____ Sex_____

Birth date:_____/_____/_____ Age:_____

Social Security #_____

Child's Home Address:_____

_____
City Sate Zip

Phone #:(____)_____

Person Responsible for account:_____

Relationship:_____

Telephone #

Mother Stepmother Guardian

Name:_____

E-Mail:_____

Home Phone #:_____

Work Phone #:_____

Social Security#:_____

Employer:_____

Occupation:_____

Father Stepfather Guardian

Name:_____

E-Mail:_____

Home Phone #:_____

Work Phone #:_____

Social Security#:_____

Employer:_____

Occupation:_____

Parent's Marital Status

Single Married

Divorced Widowed Separated

Primary Dental Insurance

Insured's Name:_____

Relationship:_____

Birth date:___/____/___ SS#:_____

Employer:_____ Date Employed_____

Occupation:_____

Insurance Company:_____

Insurance Co Phone #:_____

Group No:_____ Emp. No:_____

Insurance Co. Address_____

Ded:_____ Max Annual Benefit:_____

Orthodontic Coverage? Yes No

Additional Insurance

Insured's Name:_____

Relationship:_____

Birth date:___/____/___ SS#:_____

Employer:_____ Date Employed_____

Occupation:_____

Insurance Company:_____

Insurance Company:_____

Insurance Co Phone #:_____

Group No:_____ Emp. No:_____

Insurance Co. Address_____

Ded:_____ Max Annual Benefit:_____

Orthodontic Coverage? Yes No

Who is responsible for making appointments?

Name:_____

E-mail:_____

Relationship:_____

Home Phone #:_____

Work Phone #:_____

Best Time to Call: (Time)_____ Days_____

Medical History

Has your child had any difficulty with previous visits?_____

Comments:_____

Is Minor/ Child taking any prescription / over the counter drugs?

Yes No

Please list each one:_____

Ever been hospitalized? Yes No

Ever had Surgery? Yes No

Has you child ever had any of the following diseases or medical problems? (Please circle option that applies)

Asthma	Yes	No	Allergies	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No
HIV/AIDS	Yes	No	Hemophilia	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No
Thyroid Disease	Yes	No	Sinus Problems	Yes	No

Abnormal Bleeding Yes No

Drug/Alcohol Abuse Yes No

Handicaps / Disabilities Yes No

Congenital Heart Defect Yes No

Please explain any medical problems (including Allergies) that your child has: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services for my minor/child.

_____

Signature Date

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit? _____

Previous Dentist: _____

Child's Physician:_____

Phone Number:(_____)_____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/ Fingers? Yes No

Suck/Bite Lips? Yes No

Bite/Chew Nails? Yes No

Chew Hard Objects? (Pencils, etc.) Yes No

Grind Teeth? Yes No

Clench Jaws? Yes No

Dentist's Review

_____

_____

_____

Date:____/____/____ **Signature:**_____

Health History Update

Comments:_____

_____

_____

Date:____/____/____ Dr. Signature:_____

Comments:_____

_____

_____

Date:____/____/____ Dr. Signature:_____

Comments:_____

_____

_____

Date:____/____/____ Dr. Signature:_____