Heritage Family Dental
General, Cosmetic & Implant Dentistry
Dr. Larisa Sokolson
Dr. Robert Burstein

CHILD HEALTH HISTORY FORM

Today's Date: ____/____/_____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Child's Name: _____ *Last* _____ *First* _____ *Middle*

Nickname: _____ Age: _____ Birth Date: _____

Address: _____ *Residence address*

City: _____ State: _____ ZIP: _____

School: _____

Address: _____

Father's Name: _____

Mother's Name: _____

Father employed by: _____ *Employer name*

For how long: _____

Home Phone: (____) _____ *Please include area code.*

Business/Cell Phone: (____) _____ *Please include area code.*

Mother employed by: _____ *Employer name*

For how long: _____

Home Phone: (____) _____ *Please include area code.*

Business/Cell Phone: (____) _____ *Please include area code.*

Person financially responsible (if other than parent): _____

Relationship to child: _____

Address: _____

City: _____ State: _____ ZIP: _____

Father's Social Security Number: _____

Driver's License Number: _____

State: _____

Mother's Social Security Number: _____

Driver's License Number: _____

State: _____

Credit Card Name: _____ Number: _____ Expiration Date: _____

Dental Insurance carrier: _____

Secondary Insurance coverage: _____

Whom may we thank for referring you? _____

What is your child's favorite: sport? _____ Toy? _____ Hobby? _____ Person? _____ Fictional character? _____

Date of last visit to a dentist _____

For what service? _____

	Yes	No
Has child ever complained about dental problems? _____	☐	☐
Any unhappy dental experiences? _____	☐	☐
Any injuries to mouth/teeth/head? _____	☐	☐
Any mouth habits – thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.? _____	☐	☐
Any unusual speech habits? _____	☐	☐
Any lost teeth? _____	☐	☐
Have missing teeth been replaced? _____	☐	☐

	Yes	No
Does your child brush teeth daily? _____	☐	☐
Do you assist your child with tooth brushing? _____	☐	☐
How often? _____		
Is dental floss used? _____	☐	☐
How often? _____		
Are disclosing tablets used? _____	☐	☐
Is fluoride taken in any form? _____	☐	☐
Do you desire complete dental service for the child?	☐	☐

Child's attitude to dentistry: _____

Summary (for doctor's use): _____

Child's Physician: _____

Address: _____

Date of last physical examination: _____

Results: _____

	Yes	No
Is child under the care of a physician now? _____	☐	☐
Is child receiving medication or drugs? _____	☐	☐
Is there any excessive bleeding when cut? _____	☐	☐
Has child ever been hospitalized? _____	☐	☐
Has child ever had surgery? _____	☐	☐
Is there any allergy to penicillin or other drugs? _____	☐	☐
Are there any other allergies? Food, pollen, animals, dust, etc. _____	☐	☐

	Yes	No
Does child have good physical coordination? _____	☐	☐
Are there any emotional problems? _____	☐	☐

_____

Summary (for doctor's use): _____

Has child had any history of or difficulty with any of the following?

☐ Anemia	☐ Chronic sinus	☐ Hearing	☐ Mastoid	☐ Thyroid
☐ Asthma	☐ Convulsions	☐ Heart	☐ Measles	☐ Tuberculosis
☐ Bladder	☐ Diabetes	☐ Kidney	☐ Mononucleosis	☐ Venereal disease
☐ Cerebral palsy	☐ Epilepsy	☐ Liver	☐ Mumps	☐ Other
☐ Chicken pox	☐ Fainting	☐ Malignancies	☐ Rheumatic fever	

Summary (for doctor's use):

Please describe any current medical treatment including drugs, pending surgery, recent injuries, or any other information I should be aware of that we have not discussed.

May we request release of your child's medical records for our reference? _____

This information was discussed with and given by _____

Relationship to child _____