**CHILDREN'S DENTAL HISTORY FORM**
***PLEASE FILL OUT COMPLETELY***
***(THIS IS PROTECTED MEDICAL INFORMATION)***

Today's Date:__________________
Child's Full Name: ______________________________ Preferred Name/Nickname: _____________ Sex: _____
Home Address/ZIP: ________________________________________ ***Phone Number**: ____________________
Age: _____ **Date of Birth**: _________

**Required Parent/Guardian Information (patient is a minor):**
Parent/Guardian's Name: __________________________ Relationship to child: ____________________
Parent/Guardian Birthday: __________________ ***Parent/Guardian's Social Security Number**:___________

**Insurance:**
Does your child have Medicaid? Y N     If yes, what is the number? _________________________

Does your child have private insurance? Y N     If yes, what is the company? ________________________
Policy Holder's Name: __________________ Policy Holder's Social Security Number: _____________
Policy Holder's Birthday: ________________ Policy #: ____________________________
Company phone number: ________________ Company Address: ________________________________

**Medical/Dental:**
Is your child taking medicine for any reason? Please list names of all medicines, the reason for taking them, and how long he/she has been taking them. __________________________________________________
_______________________________________________________________________________

Has your doctor or dentist ever required your child to take antibiotics due to a heart condition before having dental care? Y N If so, why? _________________________________________________________

Is your child allergic to latex? ____ Penicillin? _____ Please list any other allergies: _____________________

Does your child drink bottled, city, or well water? Circle the correct one

Does your child have, or has your child ever had, any of the following?

____ Rheumatic Disease/Heart Problems
____ Cancer
____ Hemophilia or bleeding problems
____ Asthma
____ Tuberculosis (TB)
____ Epilepsy

Please describe any checked problems, or list any other health problems: ________________________________
_______________________________________________________________________________

Has your child seen a dentist before? Y N     If So When:__________________

During the past six months, has your child had a toothache more than once when chewing? Y N Don't know

Has your child ever had a traumatic experience at the dentist's office? Please describe ____________________

_______________________________________________ **Parent/Guardian Signature**

______________ **Date**