HEALTH HISTORY GREENBURG PEDIATRIC DENTISTRY **CONFIDENTIAL (pg. 1)**

Patient Name:________________________________**Date of Birth:** _______________

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

How often does your child brush? ____________ How often does your child floss? ___________

	Yes		No			Yes		No
Is your child's water fluoridated?	Y	or	N		Does your child take Fluoride supplements?	Y	or	N

Does your child:	Yes		No			Yes		No
Suck thumb/finger/pacifier	Y	or	N		Chew hard objects	Y	or	N
Suck/Bite lip	Y	or	N		Grind teeth	Y	or	N
Bite/Chew nails	Y	or	N		Clench Jaws	Y	or	N

Has your child ever had a traumatic mouth injury, abscess or infection?	Y	or	N
Does your child have pain or discomfort at this time?	Y	or	N
Would you describe your child as shy, frightened, apprehensive?	Y	or	N
Does your child have an unfavorable reaction to the physician (pediatrician)?	Y	or	N
Has your child had difficulty with previous dental visits?	Y	or	N

Previous dentist name: _______________________Phone #____________Date of Last Visit: __________

Child's Physician_____________________________Phone #____________Date of Last Visit:__________

Previous Hospitalizations/Surgeries/Serious Illness? When?

____ _____________

____ _____________

____ _____________

Is your child currently taking medications? Y (Yes) or N (No) (if yes, please list w/ dosage) ____________________

____

Has your child taken Fen-Phen/Redux? Y (Yes) or N (No)

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications? Y (Yes) or N (No)

(If yes, please describe) ____

____

Does your child have a history of allergies to any substance (latex, environment, etc..)? Y (Yes) or N (No)

____

Dr. Notes:

Patient Name:___________________________________Date of Birth: _______________

Has your child ever had any of the following?

	Yes		No		Yes		No
Restricted Activities due to health	Y	or	N	Arthritis	Y	or	N
Anemia or Sickle Cell Disease	Y	or	N	Bone, Muscular, or Orthopedic problems			
Asthma or Breathing Problems	Y	or	N	Stomach or Digestive Problems	Y	or	N
Bronchitis	Y	or	N	Cerebral Palsy	Y	or	N
Cancers or Other Tumors	Y	or	N	Handicaps/Disabilities	Y	or	N
Chicken Pox	Y	or	N	Chronic Sinuses	Y	or	N
Ear or Hearing Problems	Y	or	N	Endocrine or Glandular Problems	Y	or	N
Eye or Vision Problems	Y	or	N	(Thyroid, Adrenal, Parathyroid)			
Handicaps (mental, physical, emotional)	Y	or	N	Heart or Blood Pressure Problems	Y	or	N
Kidney or Urinary Tract Problems	Y	or	N	(Congenital Heart Defect or Murmur)			
Hepatitis, Jaundice or Liver Problems	Y	or	N	Tuberculosis	Y	or	N
Learning Disorders	Y	or	N	Mumps	Y	or	N
HIV/AIDS	Y	or	N	Diabetes	Y	or	N
Tonsillitis	Y	or	N	Rheumatic Fever or Rheumatic Heart Disease	Y	or	N
Abnormal Bleeding	Y	or	N	Radiation Treatments	Y	or	N
Scarlet Fever	Y	or	N	Convulsions/Epilepsy	Y	or	N
Immunizations							
Tetanus -approximate date of last booster : ___________					Y	or	N
D.P.T.	Y	or	N	Measles	Y	or	N
Polio	Y	or	N	Flu Vaccine	Y	or	N

	Yes		No
Where there any difficulties during pregnancy or birth?	Y	or	N
A persistent cough or throat clearing, not associated with a known illness (lasting more than 3 wks)	Y	or	N

Please explain any other medical problems that your child has:____
____
____
____
____

Authorization & Release

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. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

___________________________________ __________ _______________________________ ___________

Signature of patient (or parent, if minor) *Date* *Signature of Dentist* *Date*

Dr. Notes: