WE WELCOME YOUR CHILD TO OUR OFFICE!

Child's name_____ Nickname_____ Birthdate_____
Sex: M F School_____Grade____ Pets_____
Child's interests or hobbies _____
Names & ages of brothers and sisters_____
Does child live with: □ both parents □ mother □ father □ grandparent □ other_____
PLEASE NOTE: THE CUSTODIAL PARENT IS LEGALLY LIABLE FOR BILLS INCURRED AT THIS OFFICE!
Person responsible for payment of this account:_____signature_____
Who may we thank for your referral to this office?_____

MEDICAL HISTORY

Child's physician_____ Phone_____ Last examined_____
Is child in good health now? □ yes □ no If not, describe current health problems: _____
_____
Has child been hospitalized? □ no □ yes For what?_____
List any medications child takes and for what reason_____
Childhood diseases child has had: □ Measles □ Mumps □ Chicken pox □ Scarlett fever
Has child ever had any of the following? Indicate YES by circling

Adrenal disorder	Bone disorder	Ear disorder	Hepatitis	Lung disease	Skin disease
AIDS	Cancer	Eye disorder	High blood pressure	Mental retardation	Speech impediment
Allergy	Convulsions	Fainting	Hyperactivity	Muscle disorder	Stomach problems
Asthma	Diabetes	Heart disease	Jaundice	Nose or throat problems	Thyroid problems
Bleeding tendency	Emotional problems	Heart murmur	Kidney disease	Prosthetic valve or joint	Tonsillitis
Blood disease	Epilepsy	Hemophilia	Liver disease	Rheumatic fever	Tuberculosis

List all your child's allergies_____
Does child have a tendency to: □ colds □ sore throats □ ear infections Child's weight_____
Have tonsils and/or adenoids been removed? □ No □ Yes At what age?_____

DENTAL HISTORY

Is this your child's first visit to the dentist? □ Yes □ No Previous dentist_____
Date and purpose of last dental visit_____
Has child ever had a toothache? □Yes □ No Do you have fluoridated county water at your house? □ Yes □ No
What time are teeth brushed?_____ Toothpaste_____Does child floss? □ Yes □ No
Have there been any injuries to face, mouth, or teeth? □ No □ Yes Describe_____
Has child ever sucked: □ thumb □ fingers □ pacifier □ lip Until what age?_____
Does child play musical instrument? □ No □ Yes What ?_____
Does child snore loudly? □ Yes □ No Breathe through mouth much of time? □ Yes □ No When asleep? □ Yes □ No
Has any family member had orthodontics (braces)? □ Yes □ No Who?_____
Has your child ever had any unpleasant experiences with dental **or** medical care? □ No □ Yes Please describe:
_____

AUTHORIZATION: I hereby authorize Dr. Henry and/or his office staff to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for the proper dental care of my child as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Child's Parent or Guardian signature_____Date_____

Reviewed by _____Date_____

CHILD PATIENT INFORMATION • MEDICAL AND DENTAL HISTORIES