SOCIAL AND HEALTH HISTORY

This record is confidential and for use only within this office

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name _____ Nickname _____ Age _____

Sex _____ Race _____ Date of Birth _____ Social Sec. # _____

Patient's Address _____ Home Phone _____
Street City State Zip

Father's Name _____ Social Sec. # _____ Date of Birth _____

His Address _____ Phone _____
Street City State Zip

Where Employed _____ Phone _____

Mother's Name _____ Social Sec. # _____ Date of Birth _____

Her Address _____ Phone _____
Street City State Zip

Where Employed _____ Phone _____

Number to confirm appointment _____ E-mail _____

- With whom does patient live? _____
- Other children in family - names and ages _____

Closest relative besides parents _____
(Name) (Address) (Phone)

Dental Insurance? Yes ____ No ____ Policy Number _____ Other funds _____

Child's Physician _____ Family Dentist _____

Whom may we thank for referring you to our office? ☐ Doctor ☐ Parent ☐ Patient _____
Name of person referring patient

_____
Address - Street or RFD City State Zip

Health History

Please answer Yes or No

Is your child in good health? _____

Does your child have regular medical exams? _____

Is your child up to date with immunizations? _____

- Is your child presently taking medicine? _____
  If so, what? _____

Has your child experienced any unfavorable reaction to medicine? _____
If so, what? _____

Is your child presently undergoing medical treatment? _____
If so, what? _____

Has your child been hospitalized since birth? _____
Date _____ Reason _____

- Has your child ever had a blood transfusion? _____
  If so, when? _____ Reason _____

Do you have any reason to think your child may be immunosuppressed (chemotherapy, transplant surgery, etc.)? _____

Is this your child's first dental visit? _____
If not, date of last dental care _____

- Has your child had an unfavorable experience in a dental office? _____
- Does your child have a toothache? _____
- Purpose of this appointment _____

Check any of the following that may pertain to your child.

____ Heart condition	____ Tuberculosis
____ Lung problem	____ Asthma
____ Brain Injury	____ Allergies
____ Liver problem	____ Retardation
____ Kidney problem	____ Mental disorder
____ Epilepsy	____ Emotional disorder
____ Diabetes	____ Nervous disorder
____ Cerebral palsy	____ Autism
____ Bleeding disorder	____ Speech disorder
____ Sickle Cell Anemia	____ Hearing disorder
____ Hepatitis	____ Vision disorder
____ Recurrent mouth sores	____ Other

Is your child a fingersucker? _____

Does your child use a pacifier? _____

Was your child bottle-fed? _____

Was your child breast-fed? _____
Age discontinued _____

Does your child take fluoride supplements? _____
If so, since when? _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment.

_____

_____

I agree to diagnostic procedures and dental treatments and patient management techniques as found necessary and desirable by Dr. Andrew Chandler and staff for the patient named above. I will accept responsibility for this account should named responsible party fail or insurance benefit be denied. I authorize release of this information to the patient's medical doctor of record.

Date _____ _____
Signature of person legally responsible

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