# Child Health/Dental History Form

**ADA** American Dental Association®
America's leading advocate for oral health

| Patient's Name (LAST / FIRST / INITIAL) | Nickname | Date of Birth |
|---|---|---|
| Parent's/Guardian's Name | Relationship to Patient | |
| Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE) | | |
| Phone (Home / Work) | Sex M ❑ F ❑ | |

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

**Has the child had any history of, or conditions related to, any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| ❑ Anemia | ❑ Cancer | ❑ Epilepsy | ❑ HIV +/AIDS | ❑ Mononucleosis | ❑ Thyroid |
| ❑ Arthritis | ❑ Cerebral Palsy | ❑ Fainting | ❑ Immunizations | ❑ Mumps | ❑ Tobacco/Drug Use |
| ❑ Asthma | ❑ Chicken Pox | ❑ Growth Problems | ❑ Kidney | ❑ Pregnancy (teens) | ❑ Tuberculosis |
| ❑ Bladder | ❑ Chronic Sinusitis | ❑ Hearing | ❑ Latex allergy | ❑ Rheumatic fever | ❑ Venereal Disease |
| ❑ Bleeding disorders | ❑ Diabetes | ❑ Heart | ❑ Liver | ❑ Seizures | ❑ Other_____ |
| ❑ Bones/Joints | ❑ Ear Aches | ❑ Hepatitis | ❑ Measles | ❑ Sickle cell | |

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

## Child's History

| | | Yes | No |
|---|---|---|---|
| 1. | Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____ | ❑ | ❑ |
| 2. | Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ | ❑ | ❑ |
| 3. | Is the child allergic to anything else, such as certain foods? If yes, please explain: _____ | ❑ | ❑ |
| 4. | How would you describe the child's eating habits? _____ | | |
| 5. | Has the child ever had a serious illness? If yes, when: _____ Please describe: _____ | ❑ | ❑ |
| 6. | Has the child ever been hospitalized? | ❑ | ❑ |
| 7. | Does the child have a history of any other illnesses? If yes, please list: _____ | ❑ | ❑ |
| 8. | Has the child ever received a general anesthetic? | ❑ | ❑ |
| 9. | Does the child have any inherited problems? | ❑ | ❑ |
| 10. | Does the child have any speech difficulties? | ❑ | ❑ |
| 11. | Has the child ever had a blood transfusion? | ❑ | ❑ |
| 12. | Is the child physically, mentally, or emotionally impaired? | ❑ | ❑ |
| 13. | Does the child experience excessive bleeding when cut? | ❑ | ❑ |
| 14. | Is the child currently being treated for any illnesses? | ❑ | ❑ |
| 15. | Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____ | ❑ | ❑ |
| 16. | Has the child had any problem with dental treatment in the past? | ❑ | ❑ |
| 17. | Has the child ever had dental radiographs (x-rays) exposed? | ❑ | ❑ |
| 18. | Has the child ever suffered any injuries to the mouth, head or teeth? | ❑ | ❑ |
| 19. | Has the child had any problems with the eruption or shedding of teeth? | ❑ | ❑ |
| 20. | Has the child had any orthodontic treatment? | ❑ | ❑ |
| **21.** | **What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water | | |
| **22.** | **Does the child take fluoride supplements?** | ❑ | ❑ |
| **23.** | **Is fluoride toothpaste used?** | ❑ | ❑ |
| 24. | How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____ | ❑ | ❑ |
| 25. | Does the child suck his/her thumb, fingers or pacifier? | ❑ | ❑ |
| 26. | At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____ | | |
| 27. | Does child participate in active recreational activities? | ❑ | ❑ |

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____


Form S707

# Montague Dental Excellence

**Khoury & Kolnes, D.D.S.**
995 Montague Expwy., #116
Milpitas, CA 95035

**(408)259-7900**

Date: _____

FOR YOUR BENEFIT A THOROUGH EXAMINATION INCLUDING NECESSARY X-RAYS WILL BE DONE TO ENABLE US TO MAKE AN EFFICIENT AND INTELLIGENT ANALYSIS OF YOUR DENTAL PROBLEMS. AFTER THIS THOROUGH DIAGNOSIS, YOUR DENTAL PROBLEMS CAN BE DISCUSSED, METHODS OF TREATMENT OUTLINED AND PLANNED, AND YOUR INVESTMENT IN THIS HEALTH SERVICE UNDERSTOOD AND ARRANGED. THE RECEPTIONIST CAN ADVISE YOU OF THE FEE FOR THIS SERVICE.

Patient's Name _____ Nickname _____ Age _____
(last, first)

Home Address _____ Telephone # _____
(street, city, zip)

Father's Name _____ Mother's Name _____

School Patient Attends _____ Parent's Driver's Licence # _____

Father Employed By _____ Occupation _____

Business Address _____
(street, city, zip code)

Business Telephone _____ Extension _____ How Long Employed _____

Father's Dental Insurance _____ Group or Union # _____

Ins. Address _____ Father's Soc. Sec.# _____
(street, city, zip)

Mother Employed By _____ Occupation _____

Business Address _____
(street, city, zip code)

Business Telephone _____ Extension _____ How Long Employed _____

Mother's Dental Insurance _____ Group or Union # _____

Ins. Address _____ Mother's Soc. Sec.# _____
(street, city, zip)

Mother's Birthdate _____ Father's Birthdate _____

Brothers and sisters in the family (list names) _____

Former Dentist _____ Last Check Up Date _____

Person Responsible For This Account _____ Referred By: _____

PATIENTS WHO CARRY DENTAL INSURANCE SHOULD REMEMBER THAT PROFESSIONAL SERVICES ARE RENDERED AND CHARGED TO THE PATIENT, NOT TO THE INSURANCE COMPANY. WE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY AS IT IS A CONTRACT BETWEEN THE PATIENT AND THE COMPANY, NOT THE DOCTOR AND THE COMPANY. IT SHOULD BE UNDERSTOOD THAT MOST INSURANCE COMPANIES PAY ONLY A PART OF THE COST OF SERVICES, USUALLY A PERCENTAGE OF A FIXED FEE SCHEDULE ESTABLISHED BY THE COMPANY, NOT NECESSARILY THE DOCTOR's FEE. WE WILL BE HAPPY TO ASSIST IN PREPARING THE FORMS TO EXPEDITE YOUR CLAIM. TO AVOID MISUNDERSTANDING, IT IS BEST TO LEARN BEFOREHAND WHAT YOUR AMOUNT TO PAY WILL BE. OUR RECEPTIONIST WILL DISCUSS OFFICE POLICY CONCERNING PAYMENT WITH YOU.