Adolescent Health History Form

Child's Name: _____ Nickname: _____ D.O.B: _____ Male ___ Female ___

S.S.N.: _____ Age: _____ Special interests, sports, or hobbies: _____

Address: _____ City: _____ State: ____ Zip code: _____

Home Phone: _____ Referred By: _____

Preparer's Name: _____ Relationship to child: _____ D.O.B: _____ S.S.N.: _____

Address: _____ City: _____ State: ____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Occupation: _____ Employer: _____

Dental Insurance Company #1

Dental Insurance Name: _____ Phone: _____

Group #: _____ Insured's name: _____ Relationship to child: _____

Insured's S.S.N.: _____ Insured's D.O.B.: _____ Insured's Employer: _____

Employer's Address: _____ City: _____ State: ____ Zip code: _____

Dental Insurance Company #2

Dental Insurance Name: _____ Phone: _____

Group #: _____ Insured's name: _____ Relationship to child: _____

Insured's S.S.N.: _____ Insured's D.O.B.: _____ Insured's Employer: _____

Employer's Address: _____ City: _____ State: ____ Zip code: _____

1. Has the child been to the dentist before? ..... YES ◯ NO ◯

If yes, the approximate date of last visit: _____

2. Are there any dental problems that you are aware of at this time? ..... YES ◯ NO ◯

If yes, please explain: _____

3. Does the child brush his/her teeth daily? ..... YES ◯ NO ◯

Please rate your child's oral health: ..... Good ◯ Fair ◯ Poor ◯

4. Is your child currently under the care of a physician? ..... YES ◯ NO ◯

Child's physician: _____ Phone: _____ Approximate date of last visit: _____

Please rate your child's Medical Health: ..... Good ◯ Fair ◯ Poor ◯

5. Does the child have any allergies to any drugs, food, or otherwise? ..... YES ◯ NO ◯

If yes, please explain: _____

6. Is the child taking an prescription drugs? ..... YES ◯ NO ◯

If yes, please explain: _____

7. Does your child require antibiotics before dental treatment ..... YES ◯ NO ◯

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS OR PROBLEMS

Any Hospital Stays > ..... YES ◯ NO ◯

Any Operations ..... YES ◯ NO ◯

Bleeding Problems of Any Kind ..... YES ◯ NO ◯

Cancer ..... YES ◯ NO ◯

Convulsions/Epilepsy ..... YES ◯ NO ◯

Diabetes ..... YES ◯ NO ◯

Hearing Impairment ..... YES ◯ NO ◯

Heart Murmur ..... YES ◯ NO ◯

Heart Problems of Any Kind ..... YES ◯ NO ◯

Hemophilia ..... YES ◯ NO ◯

HIV+/AIDS ..... YES ◯ NO ◯

Hyperactivity ..... YES ◯ NO ◯

Rheumatic/Scarlet Fever ..... YES ◯ NO ◯

Are there any other medical conditions or concerns NOT listed above that we should be aware of at this time? ..... YES ◯ NO ◯

If yes, please explain: _____

In case of emergency, who should we contact: _____ **Relationship to child:** _____ **Phone:** _____

I understand that the information I have given is correct to the best of my knowledge, it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in the child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. The parent or guardian who accompanies the child is responsible for payment at time of service, unless prior arrangements have been approved

Signature of Parent or Guardian: _____ Date: _____