SHUMWAY DENTAL

Child Dental / Health History Form

Personal Information

Patient Name: _____
Last First MI

Address: _____
Street City State Zip

Cell / Phone Number: _____ Email: _____

Child's Birthdate: _____

Father's Name: _____ Mother's Name: _____

Child's Nickname: _____

Favorite Toy: _____ Pet's Name: _____

Dental Insurance Information

Please Circle: Single / Married / Child

Carrier: _____ Employer: _____

Subscriber Name: _____ Subscriber Birth Date: _____

Subscriber Number: _____ Group Number: _____

If no subscriber number given, please list social security number: _____

Do you have any Medicaid or State – Sponsored Insurance Plan? YES NO

If yes, please describe: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

SHUMWAY DENTAL

Dental History

Date of last dental exam: _____

What is the nature of today's visit? Routine / Regular Care Emergency

What type of water does your child drink? ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water

Does the child take fluoride supplements? YES NO

Is fluoride toothpaste used? YES NO

Has you child ever had orthodontic work? YES NO

If yes, when? _____

Does your child have any habits / behaviors we should know about?

YES	NO	Thumb-sucking	YES	NO	Poor Eating
YES	NO	Pacifier	YES	NO	Biting
YES	NO	Bottles	YES	NO	Teeth clenching / grinding

Health History

1. YES NO Any Allergies (Drug, Medications, Latex, Iodine, Nuts, Environmental, etc.)?
   Please list type and reaction below.

   _____

   _____

2. YES NO Does your child take any prescription or non – prescriptions drugs or medications?

   _____

   _____

3. YES NO Has your child had outpatient surgery or been hospitalized within the last five years?

   _____

4. YES NO Is your child in generally good health?
   Has your child had any serious illnesses YES NO
   If yes, please explain: _____

5. When was your child's last physical? _____

Child's Physician: _____ Phone Number: _____

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

YES	NO	Acid Reflux	YES	NO	Heart Disease
YES	NO	ADD / ADHD	YES	NO	Heart Murmur
YES	NO	Spectrum Disorders	YES	NO	Hepatitis
YES	NO	Asthma	YES	NO	HIV + / AIDS
YES	NO	Bleeding Disorders	YES	NO	Kidney
YES	NO	Cancer	YES	NO	Liver
YES	NO	Sinus Problems	YES	NO	Mononucleosis
YES	NO	Diabetes	YES	NO	Pervasive Developmental Disorder
YES	NO	Ear Aches	YES	NO	Rheumatic Fever
YES	NO	Hearing Problems	YES	NO	Seizures / Epilepsy
YES	NO	Scarlet Fever	YES	NO	Sickle Cell Anemia
YES	NO	Gastrointestinal / Crohn's	YES	NO	Tuberculosis
YES	NO	Growth Problems			

Patient Authorization and Release

To my knowledge all of the information on this history form is correct. Your answers are for our records only and will be kept confidential in accordance with applicable laws. I understand that by signing this I am giving my consent to dental treatment. I understand that if any change occurs in my heath during my series of appointments as a patient, I am to report it to the dental provider providing my dental treatment.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Doctor Signature Date