CHILD HISTORY FORM 1-8-18 CURRENT(Copy)#3

Patient Name:

Birth Date:

Date Created:

ANY OPERATIONS									- Marting and Total
with previous dental work? Is the child's water fluoridated? Yes No Is the child swater fluoridated? Yes No The child swater fluoridated? Yes No Does the child swater fluoridated? Yes No Comment Comment Date of Last Visit: Comment Date of Last Visit: Comment Date of Last Visit:	Why did you bring your child into the dentist today?				Comment				***************************************
Is the Child taking fluoride supplements? Yes No				○Yes ○No	i				
Has the child ever had any pain/tenderness in his/her Jaw OYES ONO Does the child brush his/her teeth daily? Oribid's Physician Comment Comment Date of Last Visit: Comment Date of Last Visit: Comment Sin the child currently under the care of a physician? Oribid's Physician Comment Comment Date of Last Visit: Comment Sin the child currently under the care of a physician? Please list any known allergies (latex, antibloitics, etc) Comment Please List any known allergies (latex, antibloitics, etc) Comment Please List any known allergies (latex, antibloitics, etc) Comment Please List any known allergies (latex, antibloitics, etc) Comment Please List any known allergies (latex, antibloitics, etc) Comment Please List any known allergies (latex, antibloitics, etc) Comment Please List any known allergies (latex, antibloitics, etc) Comment Description of the Country tolorge. Please List any known allergies (latex, antibloitics, etc) Comment Description of the Country tolorge. Please List any known allergies (latex, antibloitics, etc) Comment Description of the Country tolorge. Date List any known allergies (latex, antibloitics, etc) Comment Description of the Country tolorge. Date List any known allergies (latex, antibloitics, etc) Comment Date:	Is the child's water fluoridated?			○Yes ○No	•				
Does the child brush his/her teeth daily?	Is the Child taking fluoride supplements?			○Yes ○No	Í				
Comment		○Yes ○No	i						
Comment Date of Last Visit: Comment C	Does the child brush his/her teeth	n daily?		○Yes ○No	i				
Date of Last Visit: Comment	Child's Physician				Comment			***********************	***************************************
Date of Last Visit: Comment Comment	Phone#				Comment			**************************	***************************************
is the child currently under the care of a physician?	Date of Last Visit:			<u> </u>	L	***************************************		***********************	
Pair		ere of a physician?			L	**************************************		***************************************	•
Good Fair Poor				○ Yes ○ No					
Please list all prescription/over-the-counter drugs or herbal supplements the child is currently taking: AS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS: ABNORMAL BLEEDING	The state of the s						Poor		
Supplements the child is currently taking: AS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS: ABNORMAL BLEEDING	Please List any known allergies (la	atex, antibiotics, etc	:)		Comment [
ABNORMAL BLEEDING			nerbal		Comment			***************************************	- 73
ANY OPERATIONS	AS THE CHILD EVER HAD ANY OF	THE FOLLOWING M	EDICAL PR	OBLEMS:					
CONGENITAL HEART DEFECT	ABNORMAL BLEEDING	○Yes ○No	ADD/AD	HD	○ Yes	○ No	ANY HOSPITAL STAYS	○ Yes	○No
HANDICAPS,DISABILITIES	ANY OPERATIONS	○Yes ○No	ASTHMA		○ Yes	ON₀	CANCER	○ Yes	ON₀
HEMOPHILIA	CONGENITAL HEART DEFECT	○Yes ○No	CONVUL	SIONS/EPILEPSY	_	_	DIABETES	_	_
KIDNEY/LIVER PROBLEMS			Daniel Little - Not the Charles				2) Management of the Committee of the Co	_	~
SICKLE CELL DISEASE/TRAITS			processor of the same states			_		_	_
Please dicuss any serious medical problems that the child has DES THE CHILD HAVE ANY OF THE FOLLOWING HABITS LIP SUCKING/BITING	ANALOS (1974) ANALOS (1974) ANALOS (1974) ANALOS (1974) ANALOS (1974) ANALOS (1974)				_	_		_	_
DES THE CHILD HAVE ANY OF THE FOLLOWING HABITS LIP SUCKING/BITING	SICKLE CELL DISEASE/TRAITS	O Yes O No	TUBERCI	DEO212(10)	∪ Yes	O MO	ALLERGY TO LATEX	∪ Yes	∪ No
LIP SUCKING/BITING NURSING BOTTLE HABITS O Yes O No THUMB/FINGER SUCKING O Yes O No THUMB/FINGER SUCKING O Yes O No ONSENT AND ASSIGHMENT undersigned hereby authorizes Dr. Rangrass to take X-rays, study models, photographs or other diagnostic aids deemed appropriate by Dr. Rangrass to make rough diagnosis of the patient's dental needs. I also authorize the release of any of this information necessary to process insurance claims. I understand that the ent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved. In addition, I norize payment of insurance benefits directly to Dr. Rangrass. Date: Date: Date:		problems that the c	hild has		Comment [·	******************
LIP SUCKING/BITING NURSING BOTTLE HABITS O Yes O No THUMB/FINGER SUCKING O Yes O No NAIL BITING THUMB/FINGER SUCKING O Yes O No ONSENT AND ASSIGHMENT undersigned hereby authorizes Dr. Rangrass to take X-rays, study models, photographs or other diagnostic aids deemed appropriate by Dr. Rangrass to make rough diagnosis of the patient's dental needs. I also authorize the release of any of this information necessary to process insurance claims. I understand that the ent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved. In addition, I norize payment of insurance benefits directly to Dr. Rangrass. Date: Date: Date:	DES THE CHILD HAVE ANY OF THE	F FOLLOWING HART	TS						
NURSING BOTTLE HABITS Yes No THUMB/FINGER SUCKING Yes No Yes No Yes No THUMB/FINGER SUCKING Yes No Yes No Yes No THUMB/FINGER SUCKING Yes No Yes No THUMB/FINGER SUCKING Yes No Yes No Yes No THUMB/FINGER SUCKING Yes No Yes No Yes No Yes No Yes No Yes No THUMB/FINGER SUCKING Yes No No Yes No Y				○ No	NAIL BITING		○Ye	s ()No	
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