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

Patient Name: Birth Date: Date Created:

Why did you bring your child into the dentist today? Comment

Has your child ever had a serious/difficult problem associated with previous dental work? ◯ Yes ◯ No

Is the child's water fluoridated? ◯ Yes ◯ No

Is the Child taking fluoride supplements? ◯ Yes ◯ No

Has the child ever had any pain/tenderness in his/her jaw joint? ◯ Yes ◯ No

Does the child brush his/her teeth daily? ◯ Yes ◯ No

Child's Physician Comment

Phone# Comment

Date of Last Visit: Comment

Is the child currently under the care of a physician? ◯ Yes ◯ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please List any known allergies (latex, antibiotics, etc) Comment

Please list all prescription/over-the-counter drugs or herbal supplements the child is currently taking: Comment

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

ABNORMAL BLEEDING	◯ Yes ◯ No	ADD/ADHD	◯ Yes ◯ No	ANY HOSPITAL STAYS	◯ Yes ◯ No
ANY OPERATIONS	◯ Yes ◯ No	ASTHMA	◯ Yes ◯ No	CANCER	◯ Yes ◯ No
CONGENITAL HEART DEFECT	◯ Yes ◯ No	CONVULSIONS/EPILEPSY	◯ Yes ◯ No	DIABETES	◯ Yes ◯ No
HANDICAPS/DISABILITIES	◯ Yes ◯ No	HEARING IMPAIRMENT	◯ Yes ◯ No	HEART MURMUR	◯ Yes ◯ No
HEMOPHILIA	◯ Yes ◯ No	HEPATITIS	◯ Yes ◯ No	HIV+/AIDS	◯ Yes ◯ No
KIDNEY/LIVER PROBLEMS	◯ Yes ◯ No	MILK/GLUTEN INTOLERANCE	◯ Yes ◯ No	RHEUMATIC/SCARLET FEVER	◯ Yes ◯ No
SICKLE CELL DISEASE/TRAITS	◯ Yes ◯ No	TUBERCULOSIS(TB)	◯ Yes ◯ No	ALLERGY TO LATEX	◯ Yes ◯ No

Please dicuss any serious medical problems that the child has had: Comment

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS

LIP SUCKING/BITING	◯ Yes ◯ No	NAIL BITING	◯ Yes ◯ No
NURSING BOTTLE HABITS	◯ Yes ◯ No	THUMB/FINGER SUCKING	◯ Yes ◯ No

CONSENT AND ASSIGHMENT

The undersigned hereby authorizes Dr. Rangrass to take X-rays, study models, photographs or other diagnostic aids deemed appropriate by Dr. Rangrass to make a thorough 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 parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved. In addition, I authorize payment of insurance benefits directly to Dr. Rangrass.

Signature of Patient, Parent or Guardian:

X Date:_____

Clinical Notes Only