A World Of Smiles

Harrisonville Pediatric Dental Center

We would like to welcome you and your child to our office. Please complete the personal health history on both sides of this page. This information is essential for a thorough evaluation of our child's dental health and will help us plan for his/her emotional and dental needs. This important document will be an integral part of our continuing evaluation of your child's growth and development in these formative years. This material is confidential. Our thanks for your cooperation.

Tell us about your child Date: _____

Child's Name: _____

Nickname: _____ Gender: M ❑ F ❑

Child's Date of Birth: _____ Child's Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Emergency Telephone: _____

Child's School/Daycare: _____ Grade: _____

Who is accompanying the child today? Name: _____ Relationship to child: _____

Do you have legal custody of this child? Yes ❑ No ❑

Who may we thank for referring you? _____ Address: _____

Names and ages of other children in family: _____

Mother's Information: Stepmother ❑ Guardian ❑ Lives with child? Yes ❑ No ❑

Name: _____ Social Security #: _____

Employer: _____ Occupation: _____

Home Telephone: _____ Work Telephone: _____ Ext.: _____

Father's Information: Stepfather ❑ Guardian ❑ Lives with child? Yes ❑ No ❑

Name: _____ Social Security #: _____

Employer: _____ Occupation: _____

Home Telephone: _____ Work Telephone: _____ Ext.: _____

Medical History

Please list any serious medical problems the child has had: _____

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

Please list all medicines the child is currently taking (Give reasons): _____

Please list the medications or substances the child is allergic to: _____

Does the child have a physical or mental disability/delay? (Please list): _____

Child's Physician: _____ Telephone: _____

Address: _____

Date of Last Physical Exam: _____

Results: _____

Is the child up to date on immunizations? Yes ❑ No ❑ _____

over, please

Organs and Systems

Has this child ever had treatments of any of the following? Please check "Yes" or "No":

Yes ❑ No ❑ Circulatory-Blood
Yes ❑ No ❑ Endocrine Glands
Yes ❑ No ❑ Eyes, Ears, Nose, Throat
Yes ❑ No ❑ Gastrointestinal-Stomach
Yes ❑ No ❑ Heart
Yes ❑ No ❑ Liver
Yes ❑ No ❑ Muscles
Yes ❑ No ❑ Nervous System
Yes ❑ No ❑ Respiratory-Lungs
Yes ❑ No ❑ Skeletal-Bones
Yes ❑ No ❑ Skin
Yes ❑ No ❑ Urinary-Kidney, Bladder

❑ This child has NOThad any treatment of the above.

Illness

Has this child ever been diagnosed as having any of the following conditions?
Please check "Yes" or "No":

Yes ❑ No ❑ AIDS/HIV+
Yes ❑ No ❑ Attention Deficit/ Hyperactivity
Yes ❑ No ❑ Anemia
Yes ❑ No ❑ Allergy/Asthma
Yes ❑ No ❑ Autism
Yes ❑ No ❑ Bleeding Abnormalities
Yes ❑ No ❑ Brain Injury
Yes ❑ No ❑ Bronchitis
Yes ❑ No ❑ Cancer
Yes ❑ No ❑ Cerebral Palsy
Yes ❑ No ❑ Chicken Pox
Yes ❑ No ❑ Cleft Lip/Palate
Yes ❑ No ❑ Communicable Disease
Yes ❑ No ❑ Convulsions/Seizures
Yes ❑ No ❑ Development Delay
Yes ❑ No ❑ Diabetes
Yes ❑ No ❑ Drug or Alcohol Abuse
Yes ❑ No ❑ Epilepsy
Yes ❑ No ❑ Endocrine/Growth Disorders
Yes ❑ No ❑ Eye Problems
Yes ❑ No ❑ Fainting/Dizziness
Yes ❑ No ❑ Hearing Loss
Yes ❑ No ❑ Heart Disease/Murmur
Yes ❑ No ❑ Hemophilia
Yes ❑ No ❑ Hepatitis
Yes ❑ No ❑ Jaundice
Yes ❑ No ❑ Leukemia
Yes ❑ No ❑ Measles
Yes ❑ No ❑ Mental Retardation
Yes ❑ No ❑ Mumps
Yes ❑ No ❑ Pneumonia
Yes ❑ No ❑ Pregnancy
Yes ❑ No ❑ Psychiatric Disorder
Yes ❑ No ❑ Rheumatic Fever
Yes ❑ No ❑ Scarlet Fever
Yes ❑ No ❑ Scoliosis
Yes ❑ No ❑ Sickle Cell Anemia
Yes ❑ No ❑ Sinus Problems/Snoring
Yes ❑ No ❑ Sore Throats (frequent)
Yes ❑ No ❑ Enlarged Tonsils/Adenoids
Yes ❑ No ❑ Spina Bifida
Yes ❑ No ❑ Tuberculosis
Yes ❑ No ❑ Other: _____

❑ This child has NOThad any treatment of the above.

Dental History

Why did you bring the child to the dentist today? _____

Is this the child's first visit to a dentist? Yes ❑ No ❑
Has the child ever had a toothache? Yes ❑ No ❑
If yes, when? while eating ❑ at night ❑ spontaneous ❑ persistent ❑
Have there been any injuries to the face, mouth or teeth? Yes ❑ No ❑
If so, please describe when, where and how: _____

Has the child ever had a problem associated with previous dental treatment?
Yes ❑ No ❑
Is there a reason to expect the child will be uncooperative? Yes ❑ No ❑

Does the child have any of the following habits?
Yes ❑ No ❑ Thumb/Finger Sucking Habit
Yes ❑ No ❑ Pacifier Use
Yes ❑ No ❑ Nail Biting Habit
Yes ❑ No ❑ Nursing Bottle Feeding (age discontinued) _____
Yes ❑ No ❑ Breast Feeding (age discontinued) _____
Yes ❑ No ❑ Tooth Grinding
Yes ❑ No ❑ Mouth Breathing/Snoring

Has the child had orthodontic treatment? Yes ❑ No ❑
Has either parent had braces? Yes ❑ No ❑
Has the child ever had any pain/tenderness in the jaw joint (TMJ/TMD)?
Yes ❑ No ❑
How often are the child's teeth brushed? _____
By whom? _____
Is dental floss used? Yes ❑ How often? _____ No ❑
Is the child's water fluoridated? Yes ❑ No ❑ Don't know ❑
Source of home water supply: City Water ❑ Well ❑ Spring ❑
❑ Bottled (brand): _____
Is the child receiving fluoride supplements? Yes ❑ Tablets ❑ Drops ❑
Dose: _____mg. No ❑

Please describe any medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed:

_____

_____

_____

Please list your child's special interests, hobbies and any musical instrument played:

_____

_____

May we request release of your child's medical record for our reference?
Yes ❑ No ❑

Is there anything else you think we should know about your child?

_____

Because the patient is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before dental care can be rendered. I authorize the staff of A World Of Smiles, Harrisonville Pediatric Dental Center, Shera Sims, D.D.S., P.C., to perform appropriate preventative and therapeutic dental services for my child in accordance with accepted standards of pediatric dental care. I understnad that the information I have given is correct to the best of my knowledge, that it will be held in strict confidence and it is my responsibility to inform this office of any changes in my child's medical status. I have read and received a copy of this office'sfter one billing cycle, I am responsible for any late charges assessed at 1.5% per month (18% annually).

Signed _____ **Date** _____

Print Name _____ **Relationship to Patient** _____

Doctor's Comments: