121 Prosperous Place, Suite 12B
Lexington, KY 40509
(859) 263-1888

Child History Form

Today's Date:___/____/______

Child's Name____
Last First Initial

Nickname__________________________ SS# ________________________
Address ____
Male___ Female___ Age____ Birthdate____/____/_____ School________________
Grade____ Hobbies/Sports____
Toy_____________ Favorite Person______________ Fictional Character__________________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name__________________________________ Relation__________________________
Do you have legal custody of this child? Yes___ No___
Is the child adopted? Yes___ No___
Is the child in a foster home? Yes___ No___
Why did you bring the child to the dentist today?_______________________________________
What is the child's attitude towards dentistry? ____

Has the child ever had a serious/difficult problem associated with previous dental work? Yes___ No___
Any injuries to the mouth? Yes___ No___
Is the child's water fluorinated? Yes___ No___
Is the child taking fluorinated supplements? Yes___ No___
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes___ No___
Any orthodontic appliances worn now or in the past? Yes___ No___
Does the child brush his/her teeth daily? Yes___ No___
Floss his/her teeth daily? Yes___ No___

Child's Physician____________________________________ Phone:______________________
Date of last visit:____/____/______
Is the child currently under the care of a physician? Yes___ No___
Please describe the child's current physical health Good___ Fair___

Please list all drugs that the child is currently taking:___________________________________
____
Please list all drugs that the child is allergic to:____
____

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Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Convulsions/Epilepsy	Y	N	HIV+/AIDS
Y	N	Allergies to any Drugs	Y	N	Diabetes	Y	N	Immunizations Current
Y	N	Anemia	Y	N	Exposed to HIV but neg.	Y	N	Kidney/Liver Problems
Y	N	Any Hospital Stays	Y	N	Handicaps/Disabilities	Y	N	Measles
Y	N	Any Operations	Y	N	Hearing Impairments	Y	N	Mononucleosis
Y	N	Asthma	Y	N	Heart Murmur	Y	N	Rheumatic/Scarlet Fever
Y	N	Cancer	Y	N	Hemophilia	Y	N	Skin Rash
Y	N	Chicken Pox	Y	N	Hepatitis	Y	N	Tuberculosis (TB)
Y	N	Congenital Heart Defect	Y	N	Hives			

Does/did the child have any of the following habits?

Y	N	Lip Sucking/Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb/Finger Sucking

Whom may we thank for referring you?____
Other siblings seen by us?____
Previous Dentist:____
Last Visit Date:____/____/______

PARENT'S INFORMATION

___Mother ___Stepmother ___Guardian

Name_______________________________________ Birthdate____/____/______
Address_____________________________________ Home Phone_________________
____ Work Phone____________Ext___
Employer____________________________________ SS#_________________________

___Father ___Stepfather ___Guardian

Name_______________________________________ Birthdate____/____/______
Address_____________________________________ Home Phone_________________
____ Work Phone____________Ext___
Employer____________________________________ SS#_________________________

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PERSON RESPONSIBLE FOR ACCOUNT

Name_____________________________________ Relation_____________________
Billing Address_______________________________ Home Phone________________
____ Work Phone__________________
Employer__________________________________

Who is responsible for making appointments?____
Home Phone______________________________ Work Phone___________Ext___

PRIMARY DENTAL INSURANCE

Insur. Co. Name____________________________ Phone______________________
Address____
Subscriber's Name___________________________ Birthdate____/____/______
SS#____ Group/Policy #________________
Employer____________________________________ Address_____________________

SECONDARY DENTAL INSURANCE

Insur. Co. Name____________________________ Phone______________________
Address____
Subscriber's Name___________________________ Birthdate____/____/______
SS#____ Group/Policy #________________
Employer____________________________________ Address_____________________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature:__________________________________ Date:____/____/______