Seuss Pediatric Dentistry & Orthodontics

Child Health History

Patient Information

Name _____ Birthdate _____ Age _____ Sex: F __ M ___
Home Address _____
City, State _____ Zip _____ How long at address _____
Home Phone _____ School _____ Grade_____
Sibling name(s) _____ Custodial Parent's name(s) _____
Who may we thank for referring you to our office?_____

Responsible Party Information (custodial parent only)

Parent/Legal Guardian_____ Birthdate_____ Marital Status_____
Home address _____ Own ▢ Rent ▢
Cell # _____ Social Security # _____ Relation to patient_____
Parent/Legal Guardian_____ Birthdate_____ Marital Status_____
Employer _____ Work #_____ Cell # _____ Birthdate _____
Home address _____ Own ▢ Rent ▢
Cell number _____ Social Security #_____ Relation to patient_____
Employer _____ Occupation _____ Years employed_____
Email _____

Dental Insurance Information

Insured's Name _____ DOB _____ SS/ID# _____
Insured's Address _____
Signature of Insured for Benefits _____ Relationship to patient _____
Employer _____ Group # _____
Insurance Company _____ Phone # _____

Emergency Information

Name of nearest relative not living with you _____ (relationship) _____
Address _____ Home Phone _____
City, State _____ Zip _____ Work Phone _____

Health Provider

Child's Physician/Pediatrician:_____Phone: _____
Preferred Parmacy: _____ Phone: _____

Dental Health History

Is this your child's first visit to the dentist? ▢Y ▢N If not, how long since the last visit?_____
Previous Dentist Name _____
Were any x-rays taken at previous dental visits? ▢Y ▢N

Why did you bring your child to the dentist today? _____
Has the child ever had a serious or difficult problem associated with previous dental work? ▢Y ▢N If yes, please explain: _____
Does your child have any of the followings habits?
▢ Y ▢N Sucking finger, thumb, or pacifier? ▢Y ▢N Pain with chewing, yawning, or opening mouth wide.
▢ Y ▢N Does your child go to bed with a bottle or sippy cup?

Dental Health History Continued

☐ Y ☐ N Does your child snack frequently? What are their favorite snack foods? _____

☐ Y ☐ N Has your child had local anesthetic? Were there any problems? _____

☐ Y ☐ N Has your child been sedated for dental treatment? Were there any problems? _____

☐ Y ☐ N Has your child's teeth ever been injured? Which teeth: _____

Dental treatment for trauma: _____

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Gum Infections	☐ Orthodontics	☐ Trauma
☐ Color of Teeth	☐ Jaw Sounds	☐ Sensitive Teeth	☐ Other
☐ Grinding of Teeth	☐ Mouth Breathing	☐ Toothache	

☐ Comments: _____

Flouride History

What is your home water source: ☐ City ☐ Well ☐ Bottled ☐ Reverse Osmosis Filter

☐ Y ☐ N Does your child use a fluoride toothpaste?

☐ Y ☐ N Do you give your child any other forms of flouride? What?_____

Medical History

☐ Y ☐ N Is your child in good health? Date of last exam: _____

☐ Y ☐ N Has your child ever had a health problem? _____

☐ Y ☐ N Is your child allergic to anything? _____

☐ Y ☐ N Is your child currently taking any medications? If so, please give medications, dose, and REASON*:* _____

_____

☐ Y ☐ N Are your child's immunizations current? _____

☐ Y ☐ N Has anyone in your immediate family traveled to: Liberia, Sierra Leone or Guinea in the last 21 days?

☐ Y ☐ N If yes, please let us know when arrived into the U.S.? Month _____ Day _____

☐ Y ☐ N Is your child feverish today?

☐ Y ☐ N Have you ever been told that your child needs to take antibiotics before dental treatment?

☐ Y ☐ N Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:

_____

☐ Y ☐ N Were there any difficulties at birth? _____

Do you consider your child to be: ☐ advanced in the learning process ☐ progressing normally ☐ slow in the learning process

Please check if your child has been treated for any of the following:

☐ Abuse	☐ Cancer/tumors	☐ Heart disease	☐ Seizures
☐ ADD/ADHD	☐ Celiac/Crohn's Disease	☐ Heart murmur	☐ Sickle cell disease/trait
☐ AIDS	☐ Cerebral palsy	☐ Hepatitis	☐ Significant injuries
☐ Anemia	☐ Cleft Lip/Palate	☐ Kidney disease	☐ Sleep apnea
☐ Anxiety disorder	☐ Congenital birth defects	☐ Liver/GI disease	☐ Smoke/Vape/Smoke Exposure
☐ Arthritis	☐ Diabetes	☐ Mental delays	☐ Snoring
☐ Asthma/breathing	☐ Eczema	☐ MTHFR	☐ Speech/hearing
☐ Autism/ASD	☐ Endocrine/growth	☐ Personality/social disorders	☐ Spina bifida
☐ Bleeding/transfusions	☐ Eyesight	☐ Physical delays	☐ Thyroid problems
☐ Blood dyscrasias	☐ Frequent infections	☐ Recurrent headaches	☐ Tonsil/adenoid problems
	☐ GERD	☐ Recurrent herpes/fever blisters**	☐ Tuberculosis

**Please note that if your child has an active herpes lip lesion on the day of your scheduled appointment, we will ask you to reschedule.

Please explain any other medical issues or any boxes that have been checked:

_____

_____

Consent For Dental Treatment

Legal Guardian's Signature: _____ Date: _____