Please Print

CHILD HEALTH RECORD

POCONO DENTAL ASSOCIATES

Date: _____ Birth Date: _____

Age: _____Gender_____

SS#_____

Name: _____

Mailing Address: _____

Street City State Zip

Street Address: _____

Phone Number: _____Cell phone contact for parent or guardian _____

Father's Name: _____Date of Birth: _____

Father's Address: _____

Father's Employer: _____

Employer Address: _____

Employer Phone Number: _____Father Social Security Number: _____

Mother's Name: _____Date of Birth: _____

Mother's Address: _____

Mother's Employer: _____

Employer Address: _____

Employer Phone Number: _____Mother Social Security Number: _____

Primary Dental Insurance: _____

Company ID# Policy Number

Secondary Dental Insurance: _____

Company ID# Policy Number

Whom may we contact in case of emergency: _____Phone : _____

Who is financially responsible for treatment performed: _____

Referred By:_____

DENTAL HISTORY

Purpose of Visit: _____

Last Dental Visit: Date_____Reason: _____

Has child ever been referred to a Pedodontist (Childrens Dentist)_____	Yes	No
Are you having discomfort at this time? _____	Yes	No
If so, is there sensitivity to: Hot____ Cold____ Chewing____ Sweet____Swelling____		
Do you avoid brushing any part of your mouth because of pain? _____	Yes	No
Have you ever had any serious problem associated with previous dental treatment? _____	Yes	No
If so, please explain:_____		
Do your gums bleed while brushing or flossing? _____	Yes	No
Do your gums feel tender or swollen? _____	Yes	No
Do you feel you have bad breath? _____	Yes	No
Do your teeth seem to be moving or spreading apart or crowding? _____	Yes	No
Have you ever been treated for gum disease, surgically or non-surgically? _____	Yes	No
Do you favor chewing on one side of your mouth? If so, Right_____ or Left _____ _____	Yes	No
Do you clench or grind your teeth while sleeping or during the day? _____	Yes	No
Do your jaw joints 'pop', 'crack' or cause pain or discomfort? _____	Yes	No
Do you wear dentures, partials or orthodontic appliances? _____	Yes	No

If so, how do they fit?

_____

Type of toothbrush: Soft____ Medium____ Hard____ Nylon____Natural____

Do you swallow toothpaste? _____	Yes	No
Do you take a fluoride supplement? _____	Yes	No

If so, which one? _____

MEDICAL HISTORY

General Health: Excellent____ Good____ Fair____ Poor___
Name & Address of Physician:_____
_____Phone: _____

	Circle	
Are you physically or mentally challenged in any way? _____	Yes	No
Are you under the care of a physician now? _____	Yes	No
If so, what for? _____		
Are you taking any medications at the present time? _____	Yes	No
Please list all medications:_____		
Do you take any non-prescription drugs daily? (ie: aspirin)_____	Yes	No
If so, which ones?_____		
Have you been hospitalized during the past 2 years? _____	Yes	No
Have you been under a physician's care within the past 2 years? _____	Yes	No
Do you have, suspect you have, or have had any allergic reaction? (ie: itching, rash, swelling of hands or feet) ___	Yes	No
If so, what caused the reaction?(ie:food, medicine, product)_____		
Are you allergic to penicillin?_____	Yes	No
Have you ever had any abnormal bleeding from cuts or extractions requiring special treatment? _____	Yes	No
Do you get short of breath during mild exercise? _____	Yes	No
Have you abnormally lost or gained more than 10 lbs. In the past year? _____	Yes	No
Are you on a special diet? _____	Yes	No
Do you require more than 2 pillows to sleep? _____	Yes	No
Female: Are you pregnant now? _____	Yes	No
Are you taking oral contraceptives? _____	Yes	No

Circle any of the following which you have had or have at present:

Heart Failure	Anemia	Thyroid Disease	Yellow Jaundice
Heart Disease/Attack	Stroke	Radiation or Cobalt Therapy	Blood Transfusion
Angina Pectoris	Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Drug /Alcohol Addiction
High Blood Pressure	Ulcers	Venereal Disease (Syphilis, Gonorrhea)	Hemophilia
Heart Murmur	Emphysema	Rheumatism	Rheumatic Fever
Cough	Cortisone Medicine	Congenital Heart Lesions	Tuberculosis (TB)
Glaucoma	Cold Sores	Arthritis	Speech or Visual Impairment
Scarlet Fever	Asthma	Pain in Jaw Joints	Genital Herpes
Artificial Heart Valve	Hay Fever	HIV Positive	Epilepsy or Seizures
Heart Pacemaker	Sinus Trouble	AIDS	Fainting or Dizzy Spells
Heart Surgery	Allergies or Hives	Hepatitis—What type? _____	Nervousness
Artificial Joint	Diabetes	Liver Disease	Sickle Cell Disease
Mitral Valve Prolapse	Splenectomy	Bruise Easily	Depression
Bleeding Disorder	Hearing Impairment	Kawasaki Disease	

Has your doctor ever said you have a cancer or tumor? _____	Yes	No
Do you have any other disease, condition or problem not listed on this form? _____	Yes	No

If so, please list it here? _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Parents or Guardians must remain on premise when services are rendered to minors.

Signature of Parent or Guardian: _____ Date: _____

Date: _____ Service Rendered: _____
_____
_____
_____
_____
_____