



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

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 NOT had 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 <input type="checkbox"/> No <input type="checkbox"/> AIDS/HIV+ | Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing Loss |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Attention Deficit/
Hyperactivity | Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Disease/Murmur |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Anemia | Yes <input type="checkbox"/> No <input type="checkbox"/> Hemophilia |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Allergy/Asthma | Yes <input type="checkbox"/> No <input type="checkbox"/> Hepatitis |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Autism | Yes <input type="checkbox"/> No <input type="checkbox"/> Jaundice |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Bleeding Abnormalities | Yes <input type="checkbox"/> No <input type="checkbox"/> Leukemia |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Brain Injury | Yes <input type="checkbox"/> No <input type="checkbox"/> Measles |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Bronchitis | Yes <input type="checkbox"/> No <input type="checkbox"/> Mental Retardation |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> Mumps |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Cerebral Palsy | Yes <input type="checkbox"/> No <input type="checkbox"/> Pneumonia |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Chicken Pox | Yes <input type="checkbox"/> No <input type="checkbox"/> Pregnancy |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Cleft Lip/Palate | Yes <input type="checkbox"/> No <input type="checkbox"/> Psychiatric Disorder |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Communicable Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> Rheumatic Fever |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Convulsions/Seizures | Yes <input type="checkbox"/> No <input type="checkbox"/> Scarlet Fever |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Development Delay | Yes <input type="checkbox"/> No <input type="checkbox"/> Scoliosis |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> Sickle Cell Anemia |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Drug or Alcohol Abuse | Yes <input type="checkbox"/> No <input type="checkbox"/> Sinus Problems/Snoring |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Epilepsy | Yes <input type="checkbox"/> No <input type="checkbox"/> Sore Throats (frequent) |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Endocrine/Growth
Disorders | Yes <input type="checkbox"/> No <input type="checkbox"/> Enlarged Tonsils/Adenoids |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Eye Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> Spina Bifida |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Fainting/Dizziness | Yes <input type="checkbox"/> No <input type="checkbox"/> Tuberculosis |
| | Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____ |

This child has NOT had 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 understand 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's/ster 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:
