Smile Designs OF LONG ISLAND

Child Health/Dental History Form

EDWARD SLOYER, DDS
BRIAN J. DAVIS, DDS

Date____________

Patient's Name (LAST / FIRST / INITIAL)	Patient Gender ☐ M ☐ F	Patient Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Cell / Work)		

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other____________
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician ______________________________ Phone ______________

Child's History

Question	Yes	No
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?	☐	☐
If yes, please list: ______________________		
Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs?	☐	☐
If yes, please explain: ______________________		
Is the child allergic to anything else, such as certain foods? If yes, please explain: ______________	☐	☐
How would you describe the child's eating habits? ______________		
Has the child ever had a serious illness? If yes, when: ________ Please describe: ________	☐	☐
Has the child ever been hospitalized?	☐	☐
Does the child have a history of any other illnesses? If yes, please list: ______________	☐	☐
Has the child ever received a general anesthetic?	☐	☐
Does the child have any inherited problems?	☐	☐
Does the child have any speech difficulties?	☐	☐
Has the child ever had a blood transfusion?	☐	☐
Is the child physically, mentally, or emotionally impaired?	☐	☐
Does the child experience excessive bleeding when cut?	☐	☐
Is the child currently being treated for any illnesses?	☐	☐
Is this the child's first visit to a dentist? If not the first visit, when was the last dental visit? Date: ________	☐	☐
Has the child had any problem with dental treatment in the past?	☐	☐
Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
Has the child had any problems with the eruption or shedding of teeth?	☐	☐
Has the child had any orthodontic treatment?	☐	☐
Does the child take fluoride supplements (vitamins)?	☐	☐
Is fluoride toothpaste used?	☐	☐
How many times are the child's teeth brushed per day? ________ When are the teeth brushed?______________		
Does the child suck his/her thumb, fingers or pacifier?	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature ______________________________ Date ______________

For completion by dentist

Comments ____
____
____
____