

# Welcome



**cammarrata**  
pediatric dentistry

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(713) 666-7884 fax (713) 666-5326

## Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

### 1. Tell Us About Your Child

Child's Name \_\_\_\_\_  
Last First MI

Nickname \_\_\_\_\_  Male  Female

Siblings that we treat \_\_\_\_\_

Child's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age \_\_\_\_\_

Child's Home # (\_\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

City State Zip

Child's school \_\_\_\_\_ Grade \_\_\_\_\_

### 2. Who may we thank for referring you to our office?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 3. Mother's Information

Name \_\_\_\_\_

Marital Status:

Single  Married  Divorced  Partnered

Mother Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 4. Father's Information

Name \_\_\_\_\_

Marital Status:

Single  Married  Divorced  Partnered

Father Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 5. Who is Accompanying the Child Today?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

### 6. Person Responsible for Account

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

City State Zip

Home # (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

Cellular # (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

## 7. Dental History

Is this your child's first visit to the dentist? \_\_\_\_\_

If not, how long since the last visit to the dentist? \_\_\_\_\_

Were any x-rays taken at previous dental visits? \_\_\_\_\_

Have there been any injuries to the teeth, face or mouth? \_\_\_\_\_

\_\_\_\_\_

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Why did you bring the child to the dentist today? \_\_\_\_\_

\_\_\_\_\_

Does the child have any of the following habits?

Y  N Lip Sucking / Biting       Y  N Nail Biting

Y  N Nursing / Bottle Habits       Y  N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work?       Yes       No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Is the child's water fluoridated?       Yes       No

Is the child taking fluoride supplements?       Yes       No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)?       Yes       No

Does the child brush his/her teeth daily?       Yes       No

Floss his / her teeth daily?       Yes       No

## 8. Health History

Has the child ever had any of the following conditions?

Y  N Abnormal Bleeding       Y  N Handicaps/Disabilities

Y  N Allergies to any Drugs       Y  N Hearing Impairment

Y  N Any Hospital Stays       Y  N Heart Disease/Murmur

Y  N Any Operations       Y  N Hemophilia/Blood Disorders

Y  N Asthma       Y  N Hepatitis

Y  N Cancer       Y  N HIV + / AIDS

Y  N Congenital Birth Defects       Y  N Kidney/Liver Conditions

Y  N Convulsions/Epilepsy       Y  N Rheumatic/Scarlet Fever

Y  N ADD / ADHD       Y  N Allergies to Latex Product

Y  N Tuberculosis       Y  N Diabetes

Y  N Artificial bones/joints       Y  N Sickle Cell

Y  N Lupus

Please discuss any serious medical conditions the child has had

\_\_\_\_\_

Please list all drugs the child is currently taking \_\_\_\_\_

\_\_\_\_\_

Please list all foods, materials or drugs the child is allergic to \_\_\_\_\_

\_\_\_\_\_

Child's Physician \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Is the child currently under the care of a physician?       Yes       No

Please describe the child's current physical health...

Good       Fair       Poor

9. I understand that the information 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.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

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

### For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Cammarata Pediatric Dentistry

Child's Name \_\_\_\_\_

Date \_\_\_\_\_

Child's Age \_\_\_\_\_

Birth Date \_\_\_\_\_

To help us assess your child's dental needs, please answer these questions. Thank you.

## HEALTH HISTORY

Did birth mother have any problems during pregnancy?	YES	NO
Has your child needed frequent use of liquid medication?	YES	NO
Have the parents, caretaker seen a dentist in the last year?	YES	NO

Notes: \_\_\_\_\_

## DIET AND NUTRITION

Was your child breastfed?	YES	NO
Is your child still breastfeeding?	YES	NO
Does your child sleep with a bottle?	YES	NO
Does your child drink from a sippy cup?	YES	NO
If yes what does the sippy cup mostly contain _____		
Does your child tend to snack frequently throughout the day?	YES	NO
Is your child on a special diet?	YES	NO

Notes: \_\_\_\_\_

## FLUORIDE ADEQUACY

What is your source of water? \_\_\_\_\_

Notes: \_\_\_\_\_

## ORAL DEVELOPMENT

Child's age (in months) when first tooth erupted? \_\_\_\_\_

Has your child experienced teething problems?	YES	NO
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Notes: \_\_\_\_\_

## ORAL HYGIENE

How many times a day does your child brush their teeth?	ONCE	TWICE
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Do you assist your child in brushing his/her teeth?	YES	NO
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What type of toothpaste does your child use? \_\_\_\_\_

Does your child swallow the toothpaste?	YES	NO
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Do you floss your child's teeth?	YES	NO
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Do you, your significant other/caretaker have untreated dental needs?	YES	NO
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If yes, who? \_\_\_\_\_

Notes: \_\_\_\_\_

Circle:

Mother

Father

Guardian

Signature: \_\_\_\_\_