

Welcome



cammarrata
pediatric dentistry

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Houston, Texas 77005
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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?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease/Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Blood Disorders |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N HIV + / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Birth Defects | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Conditions |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD / ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Latex Product |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial bones/joints | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell |
| <input type="checkbox"/> Y <input type="checkbox"/> 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 _____



Childs Name _____

Date _____

Child's Age _____

Birth Date _____

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

HABITS

Did/does your child suck his/her thumb or finger? YES NO

Stopped at age _____ Still does _____ Only at night _____

Does your child grind his/her teeth? YES NO

Does your child have any other tooth related habits? YES NO

Notes: _____

DIET AND NUTRITION

How many meals per day does your child eat? _____

How many between meal snacks (including drinks other than water) does your child have on an average day? _____

Circle the items below that your child consumes:

Sour candy, sodas, raisins, chewy fruit snacks, juice, candy, crackers

If any, how often? _____ times per day _____ times per week

Notes: _____

FLUORIDE ADEQUACY

What is your source of water? _____

Does your child use any home fluoride? YES NO

If yes, what kind? _____

ORAL HYGIENE

Does your child brush his/her own teeth? YES NO

How many times a day? ONCE TWICE

What type of toothpaste does your child use? _____

Does your child use dental floss? YES NO

If yes, how often? _____ times per day _____ times per week

Do you floss your child's teeth? YES NO

If yes, how often? _____ times per day _____ times per week

Anything else you would like to add about the care of your child's teeth at home?

Circle: Mother Father Guardian Signature: _____