5 Hatfield Lane, Suite 3
Goshen, NY 10924
www.toothopiadentistry.com

Office: (845) 360-5883
Fax: (845) 360-5922
info@toothopiapediatricdental.com

Child Health/Dental History Form

Child's Name: LAST FIRST	Nickname:	Date of Birth: / /
Address: STREET ADDRESS AND APT# CITY STATE ZIP		Gender: ☐ Male ☐ Female
Parent 1 info: ☐ mother ☐ father ☐ legal guardian	Parent 2 info: ☐ mother ☐ father ☐ legal guardian	
Email address (for appointment reminders):	How did you hear about our office?	
Dental Insurance Co. Name:	ID#	Group #
Primary insured (from above): ☐ Parent 1 ☐ Parent 2	Date of Birth:	SSN:

Please list the name and number of your child's pediatrician as well as any frequently seen specialists, if applicable:
Name of pediatrician: _____ Phone Number: _____

Name of alternate pediatrician: _____ _____ Phone Number: _____

Please review **carefully** and check (☑) if your child has any history of, or condition related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy/Seizures	☐ Latex Allergy	☐ Sickle Cell Anemia	☐ STD
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Liver/Hepatitis	☐ Snoring	☐ Vision disorders
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Measles	☐ Speech/Hearing	☐ Otherwise (write below)
☐ Autism	☐ Chronic Sinusitis	☐ Headaches	☐ Mononucleosis	☐ Skin	
☐ Bladder/Kidney	☐ Diabetes	☐ HIV+/AIDS	☐ Mumps	☐ Thyroid	
☐ Bleeding disorders	☐ Ear Aches/Infection	☐ Hyperactivity	☐ Pregnancy (teens)	☐ Tobacco/Drug Use	☐ NONE
☐ Bone disorders	☐ Enlarged tonsils	☐ ADHD/ADD	☐ Rheumatic Fever	☐ Tuberculosis	

YES /NO Please complete the following health/dental questionnaire:

☐ ☐ **1. Is your child taking any medications (prescription, over-the-counter, vitamin supplements)?**
Please list all: _____

☐ ☐ **2. Is your child allergic to any of the following? Please explain details if YES:**
Medication allergies? _____

☐ ☐ **Food allergies?** _____

☐ ☐ **Metal allergies?** _____

☐ ☐ **Seasonal or Other?** _____

☐ ☐ **3. Has your child been hospitalized or had any surgery? Please explain:** _____

☐ ☐ **4. Has your child ever received sedation or general anesthesia?** _____

☐ ☐ **5. If YES to #4, were there any complications? Please explain:** _____

☐ ☐ **6. Does your child have mental, developmental, or physical impairments?**
Please explain: _____

☐ ☐ **7. Has your child experienced excessive bleeding when cut or injured?**
Please explain: _____

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☐ ☐ **8. Does your child have any genetic or inherited disorders?**
Please explain: _____

☐ ☐ **9. Is your child being treated for any other illnesses not yet discussed on this form?**
Please explain: _____

☐ ☐ **10. Are your child/s immunizations up to date? If NO, Please explain:** _____

☐ ☐ **11. Is this your child's first dental visit? If not, date of last visit?** _____

☐ ☐ **12. Have there been any injusries to your child's mouth, teeth, or head?**
please explain when/how: _____

☐ ☐ **13. How often are your child's teeth brushed per day?** _____**Time(s) of day?** ☐ AM ☐ PM ☐ Mid-day

14: Brushing is: ☐ done by an adult ☐ supervised ☐ none of the above (child brushes alone)

☐ ☐ **15: Is fluoride toothpaste used?**

☐ ☐ **16: Does your child participate in any sports or other recreational activities?** _____

☐ ☐ **17: Has your child complained of any recent dental pain? Please explain:** _____

☐ ☐ **18: Are there any other concerns not yet discussed on this form?** _____
_____

Habit and Dietary Questionnaire:

Breast-feeding: ☐ past; age when stopped ☐ current; times per day? ☐ never

Bottle use: ☐ past; age when stopped ☐ current; contents? ☐ done by an adult

Sippy cup use: ☐ straw ☐ spout ☐ not used

Pacifer use: ☐ past; age when stopped ☐ current ☐ never

Thumb/finger sucking: ☐ past; age when stopped ☐ current ☐ never

Please indicate the level of consumption for each of the items below:

Juice intake: ☐ daily ☐ 1-2 times per week ☐ raerely/never

Flavors in milk (i.e.-chocolate, vanilla, strawberry, etc.): ☐ daily ☐ 1-2 times per week ☐ rarely/never

Sticky foods (i.e.-dried fruits, fruit snacks, etc.): ☐ daily ☐ 1-2 times per week ☐ rarely/never

Does your child have any food/milk after brushing at night? ☐ regularly ☐ 1-2 times per week ☐ rarely/never

As this child's parent or legal guardian, I acknowledge that the completed information in this form is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment. Additionally, I have read the office policies and agree to abide by them.

_____ _____ _____
Parent/Legal Guardian Signature Print Name Today's Date

Office Use Only

_____ _____
Dentist Signature Name