SOCIAL AND HEALTH HISTORY

This record is confidential and for use only within this office

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name ______________________ Nickname __________ Age ______

Sex ______ Race ______ Date of Birth ______________ Social Sec. # ______________

Patient's Address ______________________ Home Phone ______________
Street City State Zip

Father's Name ______________ Social Sec. # ______________ Date of Birth ______________

His Address ______________________ Phone ______________
Street City State Zip

Where Employed ______________________ Phone ______________

Mother's Name ______________ Social Sec. # ______________ Date of Birth ______________

Her Address ______________________ Phone ______________
Street City State Zip

Where Employed ______________________ Phone ______________

Number to confirm appointment ______________ E-mail ______________

• With whom does patient live? ______________________

• Other children in family - names and ages ______________________

Closest relative besides parents ______________________
(Name) (Address) (Phone)

Dental Insurance? Yes ____ No ____ Policy Number ______________ Other funds ______________

Child's Physician ______________ Family Dentist ______________

Whom may we thank for referring you to our office? ☐ Doctor ☐ Parent ☐ Patient ______________
Name of person referring patient

____
Address - Street or RFD City State Zip

Health History

Please answer Yes or No

Is your child in good health? ______

Does your child have regular medical exams? ______

Is your child up to date with immunizations? ______

• Is your child presently taking medicine? ______

If so, what? ______________

Has your child experienced any unfavorable reaction to medicine? ______

If so, what? ______________

Is your child presently undergoing medical treatment? ______

If so, what? ______________

Has your child been hospitalized since birth? ______

Date ________ Reason ______________

• Has your child ever had a blood transfusion? ______

If so, when? ______ Reason ______________

Do you have any reason to think your child may be immunosuppressed (chemotherapy, transplant surgery, etc.)? ______

Is this your child's first dental visit? ______

If not, date of last dental care ______________

• Has your child had an unfavorable experience in a dental office? ______

• Does your child have a toothache? ______

• Purpose of this appointment ______________

Check any of the following that may pertain to your child.

____	Heart condition	____	Tuberculosis
____	Lung problem	____	Asthma
____	Brain Injury	____	Allergies
____	Liver problem	____	Retardation
____	Kidney problem	____	Mental disorder
____	Epilepsy	____	Emotional disorder
____	Diabetes	____	Nervous disorder
____	Cerebral palsy	____	Autism
____	Bleeding disorder	____	Speech disorder
____	Sickle Cell Anemia	____	Hearing disorder
____	Hepatitis	____	Vision disorder
____	Recurrent mouth sores	____	Other

Is your child a fingersucker? ______

Does your child use a pacifier? ______

Was your child bottle-fed? ______

Was your child breast-fed? ______

Age discontinued ______________

Does your child take fluoride supplements? ______

If so, since when? ______________

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment.

____

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I agree to diagnostic procedures and dental treatments and patient management techniques as found necessary and desirable by Dr. Andrew Chandler and staff for the patient named above. I will accept responsibility for this account should named responsible party fail or insurance benefit be denied. I authorize release of this information to the patient's medical doctor of record.

Date ______________ ______________________
Signature of person legally responsible

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