Mayfield Family Dentistry

Dental History for Children

Please fill in all spaces

Child's Name:_____ Preferred Name:_____

Age:____ Birthday:_____ Sex: M / F (circle one)

Home Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Social Security #:_____

Have we previously seen other family members? Yes or No

Names:_____

Do parents live together? Yes or No If no, with whom does the child live?_____

Who has legal custody of this child?_____

Parent or Guardian Email Address?_____

Parent or Guardian Information: _____Mother _____Stepmother _____Guardian

Name:_____ Date of Birth:_____ Occupation:_____

Home Address:_____ Phone:_____

Employer:_____ SS#_____ Work Phone:_____

Parent or Guardian Information: _____ Father _____ Stepfather _____ Guardian

Name:_____ Date of Birth:_____ Occupation:_____

Home Address:_____ Phone:_____

Employer:_____ SS#_____ Work Phone:_____

How did you hear about our office?_____

Primary Dental Insurance

Insured's Name:_____ Relationship to patient:_____

Birthdate:_____ Social Security #:_____

Employer:_____ KY Medicaid ID#_____

Insurance Co:_____ Group #:_____

Insurance Co Address:_____

Insurance Co. Phone:_____

Child's Health History

Name of Child's Physician:_____ Physicians Phone #:_____

Date of last Medical Examination:_____ Results:_____

Yes or No (Please circle yes or no)

Y N Is your child being treated by a physician at this time? Reason _____

Y N Is your child presently taking any medications? Name: _____

Y N Has your child ever been hospitalized? Reason: _____

Y N Is your child allergic to any medications (Drugs)? List: _____

Y N Hyperactivity/ A.D.D/ A.D.H.D	**Y N Diabetes**	**Y N Mental Disability**
Y N A.I.D.S./ H.I.V. Positive	**Y N Emotional Problems**	**Y N Mental Disorder**
Y N Allergy	**Y N Epilepsy or Seizures**	**Y N Nervous Disorder**
Y N Anemia	**Y N Eye, Ear, Nose, Throat Problems**	**Y N Eating Disorders**
Y N Arthritis	**Y N Excessive Bleeding. Hemophilia**	**Y N Radiation Treatment**
Y N Asthma	**Y N Gastrointestinal Problems**	**Y N Rheumatic Fever**
Y N Autism	**Y N Hearing Disorder**	**Y N Shunt**
Y N Blood Pressure Problems	**Y N Heart Condition**	**Y N Sickle Cell Anemia/ Trait**
Y N Blood Transfusion	**Y N Heart Murmur**	**Y N Skin Disorder**
Y N Blood/ Circulatory Problems	**Y N Hepatitis Type**	**Y N Speech Disorder**
Y N Brain Injury	**Y N Kidney/ Bladder Problems**	**Y N Tonsillectomy/ Adenoidectomy**
Y N Cancer	**Y N Latex Allergy**	**Y N Thyroid Disorder**
Y N Cerebral Palsy	**Y N Learning or School Related Problems**	**Y N Tuberculosis**
Y N Chemotherapy	**Y N Liver Problems**	**Y N Venereal Disease**
Y N Cleft Lip or Palate	**Y N Lung Problems**	**Y N Other:_____**

Has the child ever had any of the following:

Yes or No Dental History

Y N Any mouth habits: Thumb sucking, Finger sucking, lip or nail biting, mouth breathing, pacifier, etc.?

Y N Has you child had any toothaches lately? Area:_____

Y N Any injuries to the mouth, teeth, or head? Area:_____

Date of child's last dental visit: _____ For what service?_____

Previous Dentist: _____

Has your child had a dental checkup at school? _____

Has a Doctor told you that you need premedication before dental treatment? Y N

What is your main concern regarding your child's teeth at this time?_____

_____

Has your child had previous dental X-Rays? _____ Date:_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publication. I request that my insurance company pay directly to the dentist.

Note: The custodial parent or legal guardian must accompany the child to their initial appointment.

Signature of Parent/ Guardian_____ **Date:**_____