Health History

Patient Name:_____ Date of Birth:_____

□ Yes □ No Is your child in good health?

Name of child's physician:_____ Date of last physical exam:_____

□ Yes □ No Does your child have any allergies?_____

□ Yes □ No Has your child had any health problems?_____

□ Yes □ No Has your child ever been hospitalized? Please give reason and

dates:_____

_____

□ Yes □ No Is your child taking any medications? Please give medication and reason:

_____

□ Yes □ No Were there any problems at birth? If so please explain:

_____

Please check if your child has been treated for any of the following:

□ Heart disease	□ Asthma	□ Blood dyscrasias	□ AIDS/HIV
□ Liver/GI disease	□ Anemia	□ Diabetes	
□ Kidney disease	□ Rheumatic fever	□ Hepatitis	
□ Speech /hearing	□ Seizures	□ Cleft Lip/palate	
□ Cerebral palsy	□ Personality/social	□ Learning delay	
□ Cancer/tumors	□ Physical delay	□ Congenital Birth Defects	
□Recurrent Infections	□ Bleeding/transfusions	□ Autism	

Please elaborate on any checked items: _____

_____

Dental History

□ Yes □ No Has your child ever been to the dentist?

Name of dentist: _____ Date of dental exam:_____

□ Yes □ No Has your child experienced any unfavorable reactions to previous dental care?

Please explain: _____

□ Yes □ No Does your child suck a finger, thumb, or use a pacifier?
□ Yes □ No Does your child have pain when chewing, yawning, or opening wide?

Please check if your child has any of the following specific problems:

□ Cavities	□ Toothache	□ Tooth Sensitivity
□ Trauma	□ Gum Infections	□ Color of Teeth
□ Teeth Grinding	□ Other	

Please explain: _____

_____

Was your child: □ Breast fed □ Bottle fed Until what age?_____

Fluoride History

□ Yes	□ No	□ Do not know	Does your home water have fluoride?
□ Yes	□ No	□ Do not know	Does your child use fluoride toothpaste?
□ Yes	□ No	□ Do not know	Does your child use any other form of fluoride?

_____

Consent for Dental Treatment

I request and authorize Dr. Robert Testen and his staff to provide all necessary dental treatment for my child. I understand that dental treatment for children for includes efforts to guide their behavior by helping them to understand the experience in terms appropriate for their age. Dr. Testen will provide an environment conducive to this approach by using various behavior management techniques that will be discussed with me at the appropriate times.

_____ _____
Signature Date