KEYSTONE DENTISTRY
YOUR HOMETOWN DENTIST SINCE 1958

Child Health History

Child Health/Dental History Form

First Name: Middle Name: Last Name: Preferred Name: Birth Date:

Parent's/Guardian's Name: Relationship to Patient: Address:

City: State: Zip: Home Phone: Work Phone: Sex:

Have you (the parent/guardian) or the patient had any of the following diseases or problems?

- ☐ Active Tuberculosis
- ☐ Persistent cough greater than a three-week duration
- ☐ Cough that produces blood?

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Child's History

Name of child's physician: Physician Phone Number:

Has your child had any history of, or conditions related to any of the following:

- ☐ Abnormal Bleeding
- ☐ AIDS or HIV infection
- ☐ Anemia
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bronchitis
- ☐ Chest pain upon exertion
- ☐ Congestive Heart Failure
- ☐ Damaged heart valves
- ☐ Emphysema
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Hemophilia
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ other congenital heart defects
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosus

Please list any other medical problems not listed above:

Is your child taking any prescription and/or over the counter medications or vitamin supplements at this time?

Medication Name: Comments/Dosage:

Is your child allergic to any of the following?

- ☐ -COMPASSIONATE FINANCE****
- ☐ **LATEX ALLERGY**
- ☐ 1 EXAM A YEAR FROM LAST EXAM
- ☐ 10% DISCOUNT
- ☐ 2 ANYTIME- PROEXAM BWX
- ☐ 4 CLEANINGS AVAILABLE A YEAR.
- ☐ ADD/ADHD
- ☐ Allergic to Clindamycin
- ☐ ALLERGIC TO FLUORIDE
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ ALLOW EXTRA TIME FOR ANESTHESIA
- ☐ ALLOWED ONLY 2 COMPOSITES PER YR
- ☐ Alzheimers/Dementia
- ☐ AMERITAS- fee schedule
- ☐ Apprehensive
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints
- ☐ ASSURANT
- ☐ Back Problems
- ☐ BALANCE DUE TO ORTHO TX
- ☐ BCBS OF KC
- ☐ BCBS OF KC -FEDERAL
- ☐ Blood Disease
- ☐ BLOOD THINNERS
- ☐ BWX - AS NEEDED
- ☐ BWX ONE SET EVERY 2 CALENDAR YEARS
- ☐ COST SAVINGS PROGRAM
- ☐ DECEASED
- ☐ DELTA DENTAL
- ☐ Dental Phobic/ FEARFUL
- ☐ Diabetes
- ☐ DISCUSS ALL TX WITH PARENTS
- ☐ DNS - 1ST TIME
- ☐ DNS - 2ND TIME
- ☐ DNS 3RD AND FINAL TIME
- ☐ DO NOT SCHEDULE ON A MONDAY
- ☐ DO NOT USE EPINEPHRINE
- ☐ DO NOT USE LIDOCAINE
- ☐ DOES NOT HAVE INSURANCE
- ☐ DR. MYERS ONLY PT
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ FL -1204 ALLOWED 4 TIMES A YEAR
- ☐ FLUORIDE ONLY ONCE A YEAR
- ☐ FLUORIDE- 2X A YEAR ADULT AND CHILD
- ☐ FMS/PANO-80%
- ☐ Fosamax/Boniva
- ☐ FREEDOM NETWORK
- ☐ Gags easily
- ☐ GUARDIAN- fees
- ☐ Hard of Hearing
- ☐ Headaches
- ☐ Hearing Impaired
- ☐ Narcolepsy
- ☐ NO CAVITRON/ HAND SCALE ONLY
- ☐ NO EMAILS
- ☐ No MajorPerioO.S. Endo Coverage
- ☐ NO MORE PAIN RX-SEE JENNY
- ☐ NO TEXTING
- ☐ OCD
- ☐ ONLY DR MYERS
- ☐ ORTHO PATIENT
- ☐ PANO / FMS NOT COVERED
- ☐ Patient Prefers Warm H2O
- ☐ per TM schedule pt at 4 only
- ☐ Perio Mainentance Pt
- ☐ Pre-Med
- ☐ Pregnant
- ☐ Psychiatric Care
- ☐ Pt alternates w/periodontist
- ☐ PT HAS A POWER OF ATTORNEY
- ☐ PT REQUEST LIDOCAINE ONLY
- ☐ PT REQUESTS NITROUS /PT CAN NOT GET NUMB
- ☐ Radiation Treatment
- ☐ Reads Lips
- ☐ REFUSES RECOMMEND RECALL
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ SEC insurance letter in Smart Doc
- ☐ SEE ACC''T NOTES BEFORE SCHEDULING

- ☐ BWX ONE SET PER CALENDAR YEAR
- ☐ CALL CELL TO CONFIRM FIRST
- ☐ CAN''T TAKE IBUPROFEN/ADVIL
- ☐ CANCELLED - 1ST APPOINTMENT
- ☐ CANCELLED - 2ND APPOINTMENT
- ☐ CANCELLED - 3RD APPOINTMENT
- ☐ Cancer
- ☐ Check Ins Waiting Period
- ☐ Chemical Dependency
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Communicate by e-mail only
- ☐ Confirm @ wk #
- ☐ Confirm appt with mom
- ☐ CONFIRM ON HOME ONLY
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis Jaundice or Liver Disease
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ HUMANA
- ☐ HYPER-SENSITIVE TEETH
- ☐ INSURANCE HAS A LIFETIME MAX
- ☐ LIFETIME DEDUCTIBLE MET
- ☐ MAX ADVANTAGE
- ☐ Medicaid
- ☐ MEDICARE- BLUE ADVANTAGE ACCESS - PPO
- ☐ MEDICARE- FEE SCHEDULE
- ☐ METLIFE
- ☐ NAME ALERT
- ☐ SEE ACCOUNT NOTES
- ☐ Sensory Disorder
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Spanish Speaking
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Termination Letter Sent
- ☐ TRICARE UNITED CONCORDIA OUT OF NETWORK
- ☐ Ulcer
- ☐ VA PATIENT
- ☐ WAITING PERIODS -SEE BREAKDOWN
- ☐ WEARS OXYGEN

Is your child allergic to anything else, such as certain foods?

○ Yes
○ No

If yes, please explain:

How would you describe your child's eating habits?

Has your child ever had a serious illness?

○ Yes
○ No

If yes, when:

Please explain:

Has your child ever been hospitalized?

○ Yes
○ No

Please explain:

Does your child have a history of any other illnesses?

If yes, please list:

Is this your child's first visit to a dentist?

○ Yes
○ No

If it's not your child's first visit, what was the date of their last visit to the dentist?

	Yes	No
Has your child ever received a general anesthetic?	○	○
Does your child have any inher ited problems?	○	○
Does your child have any spee ch difficulties?	○	○
Has your child ever had a bloo d transfusion?	○	○
Is your child physically, mental ly, or emotionally impaired?	○	○
Does your child experience ex cessive bleeding when cut?	○	○
Is your child currently being tr eated for any illnesses?	○	○

	Yes	No
Has your child had any proble m with dental treatment in the past?	○	○
Has your child ever had dental radiographs (x-rays) exposed?	○	○
Has your child ever suffered a ny injuries to the mouth, head or teeth?	○	○
Has your child had any proble ms with the eruption or shedd ing of teeth?	○	○
Has your child had any orthod ontic treatment?	○	○

Does your child take fluoride supplements?

○ Yes
○ No

Does your child use fluoride toothpaste?

○ Yes
○ No

How many times does your child brush their teeth per day?

When are your child's teeth brushed?

Does your child suck their thumb, fingers or pacifier?

○ Yes
○ No

At what age did your child stop bottle feeding?

At what age did your child stop breast feeding?

Does your child participate in any active recreational activities?

NOTE: Both the doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature:

Sign