



Adolescent Health History Form

Child's Name: _____ Nickname: _____ D.O.B: _____ Male ___ Female ___

S.S.N.: _____ Age: _____ Special interests, sports, or hobbies: _____

Address: _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ Referred By: _____

Preparer's Name: _____ Relationship to child: _____ D.O.B: _____ S.S.N.: _____

Address: _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Occupation: _____ Employer: _____

Dental Insurance Company #1

Dental Insurance Name: _____ Phone: _____

Group #: _____ Insured's name: _____ Relationship to child: _____

Insured's S.S.N.: _____ Insured's D.O.B.: _____ Insured's Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip code: _____

Dental Insurance Company #2

Dental Insurance Name: _____ Phone: _____

Group #: _____ Insured's name: _____ Relationship to child: _____

Insured's S.S.N.: _____ Insured's D.O.B.: _____ Insured's Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip code: _____

1. Has the child been to the before? YES ___ NO ___

If yes, the approximate date of last visit: _____

2. Are there any dental problems that you are aware of at this time? YES ___ NO ___

If yes, please explain: _____

3. Does the child brush his/her teeth daily? YES ___ NO ___

Please rate your child's oral health: Good ___ Fair ___ Poor ___

4. Is your child currently under the care of a physician? YES ___ NO ___

Child's physician: _____ Phone: _____ Approximate date of last visit: _____

Please rate your child's Medical Health: Good ___ Fair ___ Poor ___

5. Does the child have any allergies to any drugs, food, or otherwise? YES ___ NO ___

If yes, please explain: _____

6. Is the child taking an prescription drugs? YES ___ NO ___

If yes, please explain: _____

7. Does your child require antibiotics before dental treatment YES ___ NO ___

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS OR PROBLEMS

Any Hospital Stays > YES ___ NO ___

Heart Murmur YES ___ NO ___

Any Operations YES ___ NO ___

Heart Problems of Any Kind YES ___ NO ___

Bleeding Problems of Any Kind YES ___ NO ___

Hemophilia YES ___ NO ___

Cancer YES ___ NO ___

HIV+/AIDS YES ___ NO ___

Convulsions/Epilepsy YES ___ NO ___

Hyperactivity YES ___ NO ___

Diabetes YES ___ NO ___

Rheumatic/Scarlet Fever YES ___ NO ___

Hearing Impairment YES ___ NO ___

Are there any other medical conditions or concerns NOT listed above that we should be aware of at this time? YES ___ NO ___

If yes, please explain: _____

In case of emergency, who should we contact: _____ Relationship to child: _____ Phone: _____

I understand that the information I have given is correct to the best of my knowledge, it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in the child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. The parent or guardian who accompanies the child is responsible for payment at time of service, unless prior arrangements have been approved

Signature of Parent or Guardian: _____ Date: _____