HEALTH HISTORY INFANT SCREEN

Central CT. Pediatric Dentistry and Orthodontics

Date: ______________________

Patient Name: ____ M ☐ F ☐ DOB: ________ Nick Name: ___________________________

Address: ____ City: ____________________________ State ______ Zip _________

Brother's/Sister's Names and Ages : ____

ACCOUNT INFORMATION

FATHER'S NAME: ____

ADDRESS: ____

PHONE (HOME): __________________ (WORK): ________________

CELL: ___________________________

EMAIL: ____

EMPLOYER/DIVISION: ______________________________________

ADDRESS: ____

DENTAL INS. CO.: ____

INS. ADDRESS: ____

POLICY # ____

SOCIAL SECURITY # _______________________________________

DATE OF BIRTH: ____

MOTHER'S NAME: ____

ADDRESS: ____

PHONE (HOME): __________________ (WORK): ___________________

CELL: _________________________

EMAIL: ____

EMPLOYER/DIVISION: ____

ADDRESS: ____

DENTAL INS. CO.: ____

INS. ADDRESS: ____

POLICY # ____

SOCIAL SECURITY # ____

DATE OF BIRTH: ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

REASON FOR VISIT: ☐ ROUTINE SCREENING ☐ DEVELOPMENTAL CONCERNS ☐ TRAUMA ☐ OTHER ______________________

DENTAL DEVELOPMENTAL HISTORY

FIRST TOOTH: ____________ MONTHS

HISTORY OF TOOTH DECAY:	YES	NO
MOTHER	☐	☐
FATHER	☐	☐
SIBLINGS	☐	☐
FLUORIDE USAGE:		
TOOTHPASTE	☐	☐
CITY WATER	☐	☐
TABLETS/DROPS	☐	☐
WELL WATER	☐	☐

TOOTH CLEANING:

FREQUENCY ______ x PER DAY

HAS YOUR CHILD HAD ANY:	YES	NO
INJURY TO TEETH	☐	☐
TOOTH PAIN	☐	☐
PACIFIER HABIT	☐	☐
FINGER/THUMB HABIT	☐	☐
INJURY TO MOUTH	☐	☐
ABSCESSES	☐	☐
GRINDING OF TEETH	☐	☐
STAINED TEETH	☐	☐
FREQUENT SORE THROATS	☐	☐
FREQENT EAR INFECTION	☐	☐
BAD BREATH	☐	☐

FEEDING HISTORY

BREAST FED:

	YES	NO
TOTALLY (NO BOTTLE)	☐	☐
FREQUENCY ___/DAY	☐	☐
BEDTIME	☐	☐
ON DEMAND	☐	☐
SUPPLEMENTAL BOTTLE	☐	☐

AGE WEANED _______

BOTTLE FED:

	YES	NO
READY-TO-FEED FORMULA	☐	☐
FORMULA WITH WATER	☐	☐
ON DEMAND	☐	☐
BEDTIME BOTTLE	☐	☐

CONTENTS ______________

AGE BOTTLE STOPPED ____

PREGNANCY HISTORY

	YES	NO
NORMAL PREGNANCY	☐	☐
SEVERE MORNING SICKNESS	☐	☐
PHYSICAL TRAUMA	☐	☐

	YES	NO
ILLNESS	☐	☐
MEDICATIONS TAKEN?	☐	☐

WHAT KINDS? _____________________

OTHER ______________________________

CHILD'S BIRTH HISTORY

	YES	NO
FULL TERM	☐	☐
PREMATURE: ______weeks		
FORCEPS DELIVERY	☐	☐
CESAREAN DELIVERY	☐	☐

BIRTH WEIGHT _____

COMPLICATIONS DURING DELIVERY: _______________

____

____

CHILD'S NEONATAL HISTORY (birth to 6 months)

	YES	NO
Breathing difficulties	☐	☐
High fevers	☐	☐
Intubation	☐	☐
Medications	☐	☐
Feeding difficulties	☐	☐
Serious illness	☐	☐
Any teeth at birth	☐	☐

Child's Physician: ___________________________Address: ____Phone: ______________

Date of last examination: __________ Results:____

IS CHILD:

	YES	NO
1. Under the care of a physician now?	☐	☐
2. On medication now?	☐	☐
3. Ever been in a hospital?	☐	☐
Why? ________________________		
4. Taking any antibiotics now?	☐	☐
In the past?	☐	☐
5. Bleed excessively when cut?	☐	☐
6. Family or patient latex allergy?	☐	☐
7. Any other allergies?	☐	☐
8. Physical problems?	☐	☐
9. Learning difficulties?	☐	☐
10. Immunizations current?	☐	☐
11. Any surgeries?	☐	☐

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___ Anemia
___ Asthma
___ Bladder
___ Cerebral Palsy
___ Chicken Pox
___ Chronic Sinus
___ Convulsions
___ Diabetes
___ Epilepsy
___ Fainting
___ Hernia
___ Frequent Infections
___ HIV
___ Hearing
___ Heart
___ Heart Murmur
___ Hepatitis
___ High Fever
___ Mononucleosis
___ Kidney
___ Liver
___ Malignancies
___ Mastoid
___ Measles
___ Mumps
___ Rheumatic Fever
___ Thyroid
___ Transfusions
___ Tuberculosis
___ Other

Please describe any current or past medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of:

____

____

May we request release of your child's medical records for our reference? ☐ YES ☐ NO

SUMMARY: (for doctor's use)

PERMIT FOR TREATMENT UPON A MINOR

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. I, being the parent or guardian of the above minor patient have authorization and do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment. I authorize the administration of anesthetics or analgesics, which may be deemed advisable by the Doctor. I will be informed of all services and their charges by this office before any of the services are rendered.

Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligations incurred on this child for dental treatment.

I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with: ____

(Signature of Parent/Guardian and Relationship to Child)