

Child Health/Dental History Form



American Dental Association
www.ada.org

Patient's Name LAST FIRST INITIAL			Nickname	Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		
Address PO OR MAILING ADDRESS CITY STATE ZIP CODE					
Phone Home Work			Sex M <input type="checkbox"/> F <input type="checkbox"/>		
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.					
Has the child had any history of, or conditions related to, any of the following:					
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
Please list the name and phone number of the child's physician:					
Name of Physician _____			Phone _____		

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____	4. <input type="checkbox"/>	<input type="checkbox"/>
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?	14. <input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed?	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?	20. <input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water	21. <input type="checkbox"/>	<input type="checkbox"/>
22. Does the child take fluoride supplements?	22. <input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____	26. <input type="checkbox"/>	<input type="checkbox"/>
27. Does child participate in active recreational activities?	27. <input type="checkbox"/>	<input type="checkbox"/>

NOTE: Both 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 _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: Medical Alert Premedication Allergies Anesthesia Reviewed by _____

Date _____



Dmitry Gelfand, DDS

Family and Cosmetic Dentistry

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— coventrydental@yahoo.com —

APPOINTMENT POLICY

PLEASE READ

You will receive a reminder call through our automated system prior to your appointment. This is a courtesy service which we make every effort to conduct on a regular basis. It is, however, ultimately your responsibility to manage your appointments.

- Any cancelled visit less than 24 hour notice could be subjected to a cancellation fee.
- Any missed visit without prior 24 hour notice may be subjected to a broken appointment fee (possibly equal to the full cost of the appointment)
- Patients that are more than 15 minutes late for their scheduled appointments will be charged a broken appointment fee.

Print Name

Date

Signature

E-mail

Cellphone #

Coventry Family Dental
903 Tiogue Avenue
Coventry, RI 02816

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this
office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

One last thing....

Who may we thank for referring you to our office?

Name: _____

Refer a friend or family member and receive a special gift!!



Don't forget to like our facebook page for monthly specials!!



Thank you!