Harte Dental Pediatric Health History Form

Patient's Name (First, Middle, Last): _____ Sex: M F
Preferred name/nickname: _____ Date of Birth: _____
Mailing Address: _____
_____
How did you hear about our office? _____

Parent/Legal Guardian Contact Information

Guardian 1:
Name: _____ Relationship: _____
Preferred Contact Phone #: _____ Email: _____

Guardian 2:
Name: _____ Relationship: _____
Preferred Contact Phone #: _____ Email: _____

Was your child adopted? Y N If yes, at what age? _____
Whom should we contact to schedule appointments? _____
Whom should we contact regarding billing? _____
With whom does the patient live? _____

Insurance Information

Primary Subscriber Name (as written on policy): _____
Group Number: _____ Employer name: _____
Primary Subscriber Number: _____ Date of Birth: _____

Secondary Subscriber Name (as written on policy): _____
Group Number: _____ Employer name: _____
Secondary Subscriber Number: _____ Date of Birth: _____

Medical History

Name of patient's pediatrician: _____
Pediatrician practice/clinic name: _____
Pediatrician location (city, state): _____
Pediatrician phone number: _____ Date of last visit: _____

Does your child have any chronic medical conditions?	Y	N
Has your child been hospitalized or been to the ER?	Y	N
Has your child missed any scheduled vaccinations?	Y	N
Were there any complications in pregnancy/delivery for your child?	Y	N
Has your child ever had surgery?	Y	N

Please provide more detail on "Yes" answers here: _____
_____
Please list any allergies your child has: _____
_____
Please list any medications your child is taking: _____
_____

Please check any health conditions your child has now or has had in the past:

- ❑ Acid reflux/heartburn
- ❑ ADD/ADHD
- ❑ Asthma/Reactive Airway Disease
- ❑ Arthritis
- ❑ Autism Spectrum Disorder
- ❑ Behavioral/Emotional Problems
- ❑ Blood Disorders
- ❑ Brain Injury/Disorder
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Child Abuse
- ❑ Cleft Lip/Palate
- ❑ Cystic Fibrosis
- ❑ Birth defect
- ❑ Developmental Delay
- ❑ Diabetes
- ❑ Digestive/Gastro-intestinal Disorder
- ❑ Eating Disorders
- ❑ Eczema
- ❑ Epilepsy/Seizures
- ❑ Headaches or Migraines
- ❑ Heart disorder
- ❑ Hemophilia
- ❑ HIV/AIDS
- ❑ Hormone/endocrine disorder
- ❑ Infectious disease
- ❑ Kidney/bladder disorder
- ❑ Learning disorder
- ❑ Liver/gallbladder disorder
- ❑ Lung disorder
- ❑ Nutritional deficiency
- ❑ Sinus disorder
- ❑ Skin disorder
- ❑ Sleep disorder
- ❑ Speech disorder
- ❑ Tonsil/adenoid disorder
- ❑ Tuberculosis
- ❑ Other

Please provide further detail for positive answers: _____
_____

Dental History

What is your main reason for making this appointment? _____
Has your child seen a dentist before? Y N If yes, please fill out the following:
Previous dentist's name: _____ Office location: _____
Date of last visit: _____ Purpose of last visit: _____
Do you anticipate that your child may be uncooperative/highly anxious? Y N
Has your child ever had any problems with past dental treatment? Y N
Has your child ever had an injury to the head/jaws/face? Y N
Please check any activities/sports in which your child participates:

- ❑ Baseball
- ❑ Basketball
- ❑ Biking
- ❑ Boxing
- ❑ Field Hockey
- ❑ Football
- ❑ Gymnastics/Tumbling
- ❑ Ice Hockey
- ❑ Ice Skating
- ❑ Lacrosse
- ❑ Martial Arts
- ❑ Rollerskating
- ❑ Rugby
- ❑ Skateboarding
- ❑ Skiing
- ❑ Soccer
- ❑ Softball
- ❑ Volleyball
- ❑ Wrestling
- ❑ Other: _____

Does your child wear an athletic mouthguard for the above activities? Y N

Nutrition and Habits

Does your child have any of the following habits? (Circle all that apply)
Pacifier use Sippy Cup use Bottle to sleep Finger-sucking

What kind(s) of water does your child primarily drink?
Tap (Unfiltered) Tap (Filtered) Bottled Well

How much of the following foods/drinks does your child have in an average day?
Juice: _____ Sports Drinks: _____ Soda: _____
Sweetened milk: _____ Candy: _____
Cookies/crackers: _____)_____ Fruit snacks/gummies: _____

How often does your child brush their teeth? 0x/day 1x/day 2x/day >2x/day
Does a parent assist with brushing? Y N Is a toothpaste with fluoride used? Y N
What kind of toothbrush is used? Manual Electric
How often does your child use dental floss? 0x/day 1x/day >1x/day
Does a parent assist with flossing? Y N
Do your child's gums bleed when brushed/flossed? Y N

I affirm that all above information is true to the best of my knowledge:
Signature: _____ Date: _____
Dr. Signature: _____ Date: _____