



Child Health Questionnaire

In order to provide a complete dental exam for your child, please answer the following questions as completely as possible.

Date _____/_____/_____

Child's Name _____ Child's Soc. Sec. No. _____

Birthdate _____/_____/_____ Age _____ Sex _____ Nickname _____

Father's Name _____ Mother's Name _____

Favorite Pet or Toy _____ Pet's Name _____

Is Child Adopted? Yes No Legal Guardian's Name _____

Child's Physician _____ Phone _____

Date of Last Physical Examination _____

How is your child's general health? _____

Has your child had any serious illnesses? Yes No

If yes, describe _____

Has your child ever been hospitalized? Yes No

For what reason? _____

Is your child receiving any medication at this time? Yes No

If yes, describe _____

Has your child ever had an allergic reaction to the following

Dental Anesthetics Antibiotics Food Drugs Latex

Please describe _____

Has your child ever received a blow or injury to his/her head or teeth? Yes No

Describe _____

Has your child ever been treated with X-ray or radiation therapy? Yes No

Has your child ever had any of the following conditions? *Please check:*

	Yes	No	Age		Yes	No	Age		Yes	No	Age
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Aids or HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____	TB (Tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Circle</i> Disease or Trait			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other (Please describe)	_____		
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			

Does your child have any habits we should know about, such as:

Poor Eating Habits Thumb Sucking Pacifier Bottles Other _____

Does your child receive fluoride in: Drinking water at home Yes No By Prescription Yes No

Has your child had any unpleasant dental experiences? Yes No

How can we help? _____

Date of last dental examination _____/_____/_____

Has your child ever had orthodontic treatment? Yes No When? _____

What is the nature of today's visit? Regular Exam Emergency State Problem: _____ Other

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 _____/_____/_____

Parent or Legal Guardian's Consent for Treatment

Patient : _____ Chart No. _____

As parent or legal guardian of the patient named above, I hereby grant permission to the staff of Cincinnati Dental Services to provide dental care for him/her. This consent extends to the care deemed necessary by the doctor(s) to treat the conditions present. This consent includes but is not exclusive to routine preventive and restorative procedures. I also extend my consent to treatment provided when the patient is unaccompanied or accompanied by someone other than me.

I understand that treatment is recommended and rendered based on what the doctor(s) believes is in the best interest of the patient. This treatment is not based on insurance coverage, and I understand that failure of an insurer to pay for a procedure does not relieve me of the financial obligation for this treatment. I further understand that no guarantees or promises regarding treatment outcome are made by Cincinnati Dental Services.

Unless I provide written notification to the contrary, this consent will remain in effect as long as the patient is a minor or as long as I am his/her legal guardian.

Signature of parent or legal guardian

Date

Signature of Doctor

Date