SOCIAL AND HEALTH HISTORY

This record is confidential and for use only within this office

I. SOCIAL HISTORY

Email _____

Child's Name_____ Sex _____ Birthdate_____ Grade ____

By what name does you child prefer to be called?_____ School _____

Brothers_____ Sisters _____ Hobbies & Pets _____

Home Address_____ Home Phone _____

City_____ State_____ Zip _____

Father's Name _____ SS # _____

Employer_____ Work Ph _____ Cell Ph_____

Mother's Name _____ SS#_____

Employer_____ Work Ph _____ Cell Ph_____

Do Mother, Father and Child live together? ☐ Yes ☐ No If not, with whom does the child live? _____

Emergency contact name and phone number _____

Person financially responsible for this account? ☐ Mother ☐ Father Other _____

If "other," give person's name _____ Relationship _____

Whom may we thank for your referral to our office?_____

Has this office rendered treatment to any other family member? ☐ Yes ☐ No

Please list names _____

II. MEDICAL HISTORY

Present health problems?_____ Height _____ Weight _____

Child's physician(s) _____

☐ Yes ☐ No Are your child's immunizations up to date? If no, explain _____

_____

☐ Yes ☐ No Does your child have physical or mental disabilities? If yes, explain _____

_____

☐ Yes ☐ No Has your child ever been hospitalized? Date _____ Reason _____

_____

☐ Yes ☐ No Has your child ever had a blood transfusion? Date _____ Reason _____

_____

☐ Yes ☐ No Has your child received emergency medical treatment within the last year? If yes, explain _____

_____

☐ Yes ☐ No Has your child ever had hearing, sight, speech, or learning problems? If yes, explain _____

_____

☐ Yes ☐ No Is your child currently receiving speech therapy? If yes, by whom _____

☐ Yes ☐ No Has your child ever received injuries to the head, jaw, mouth, or teeth? If yes, describe _____

_____

☐ Yes ☐ No Is your child allergic to any medicine or food? If yes, what _____

_____

☐ Yes ☐ No Is your child taking any medicine now? If yes, what _____

_____

Date of child's last physical examination?_____

Date of last Tetanus shot?_____

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MEDICAL ALERT

FOR GROWING PATIENTS ONLY:

Female patients

☐ Yes ☐ No Has patient started her monthly period? Age started _____

☐ Yes ☐ No Has patient any other signs of pubertal development? (axillary hair, etc.) _____

Male patients

☐ Yes ☐ No Has patient's voice changed?

☐ Yes ☐ No Has patient started to shave?

☐ Yes ☐ No Has patient shown other signs of pubertal development? (axillary hair, etc.) _____

Indicate any of your child's past or present conditions:

☐ Yes ☐ No Anemia	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Mental Retardation
☐ Yes ☐ No Asthma	☐ Yes ☐ No Eye disorders	☐ Yes ☐ No Muscle disorders
☐ Yes ☐ No Auto Immune Deficiency	☐ Yes ☐ No Heart condition/murmur	☐ Yes ☐ No Nose/Throat disoders
☐ Yes ☐ No Bleeding tendency	☐ Yes ☐ No Hemophilia	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Blood disease	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Skin disease
☐ Yes ☐ No Bone disorder	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Sickle-Cell Anemia
☐ Yes ☐ No Convulsions	☐ Yes ☐ No HIV	☐ Yes ☐ No Stomach problems
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Hyperactivity	☐ Yes ☐ No Tumors
☐ Yes ☐ No Ear disorders	☐ Yes ☐ No Kidney disease	☐ Yes ☐ No Other _____
☐ Yes ☐ No Emotional problems	☐ Yes ☐ No Liver disease (Jaundice)	_____
☐ Yes ☐ No Endocrine disorders	☐ Yes ☐ No Lung disease	_____

III. DENTAL HISTORY

☐ Yes ☐ No Is this your child's first visit to the dentist?

☐ Yes ☐ No Has your child experienced any unfavorable reactions from previous dental or medical care? If yes, explain _____

☐ Yes ☐ No Has your child had a toothache recently?

☐ Yes ☐ No Has your child received any trauma to his/her teeth?

☐ Yes ☐ No Does your child have any history of mouthbreathing, thumbsucking, fingersucking, pacifier, lip/nail biting or other habits? (If yes, underline) Do they currently have this habit? ☐ Yes ☐ No

☐ Yes ☐ No At what age did your child stop using a nursing bottle? _____

☐ Yes ☐ No Is your child taking any vitamins or fluorides?

☐ Yes ☐ No Does your family drink well or city water _____

☐ Yes ☐ No How often are your child's teeth brushed per day?_____ By whom? _____

☐ Yes ☐ No Does your child have a dental condition about which you are especially concerned?
If yes, explain_____

_____

☐ Yes ☐ No Is there anything else about your child that you think I should know in order to better plan his/her dental treatment? _____

IV. CONSENT

I acknowledge that the above information is correct and authorize Dr. Barbara Utermark and staff to provide dental and related medical/surgical treatment as deemed necessary utilizing proper and acceptable methods to complete same, including diagnostic radiographs and photographs. I also understand that payment is expected as services are rendered.
Method of Payment: ☐ Check, ☐ Cash, ☐ Credit Card.

Parent or Legal Guradian _____ Date_____