Boston Children's Hospital

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DENTAL PATIENT INFORMATION AND HEALTH HISTORY FORM

Department of Dentistry

Telephone: (617) 355-6571

In order to ensure that your child receives the best care at our clinic, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical reasons.

PATIENT INFORMATION AND HEALTH HISTORY

Child's Name: _____ Nickname: _____ Sex: _____

Age: _____ Birth date: _____ Interests/Hobbies: _____

Child's Main Residential or
Mailing Address (could be PO Box): _____ City: _____ State: ____ Zip: _____

Home Telephone: _____

Mother's Name: _____ Occupation: _____ Work Phone: _____

Cell: _____ Email: _____

Father's Name: _____ Occupation: _____ Work Phone: _____

Cell: _____ Email: _____

What is the best form of contact? _____

What is the best way to reach you? _____

What is the parent's primary language? _____ The child's? _____

Date of Adoption, if applicable: _____

Names and ages of brothers and sisters: _____

_____

Whom may we thank for referring you? _____

Whom may we call in case of emergency?

Name: _____ Relationship: _____ Phone: _____

Child's Physician/Pediatrician: _____ Phone#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Has child been a patient at Children's Hospital Clinics in the past (or presently): Y☐ N☐

Which clinic(s)?: _____

Child's Previous Dentist: _____ Phone#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

BOSTON CHILDREN'S HOSPITAL, 300 LONGWOOD AVE., BOSTON, MA 02115

Rev 2/13

150463

MEDICAL HISTORY

1. Medical conditions: Does your child have any history of the following? *(Check all that apply)*

General conditions
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Gastrointestinal disorders
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Rheumatic fever

Behavior/Learning
- ☐ ADHD/ADD
- ☐ Anxiousness/Nervousness
- ☐ Autism
- ☐ Behavior issues: Type_____
- ☐ Emotional problems:

Type_____
- ☐ Learning problems:

Type_____
- ☐ Psychiatric disorder:

Type_____

Developmental
- ☐ Brain injury
- ☐ Cerebral palsy
- ☐ Cleft lip/palate
- ☐ Down Syndrome
- ☐ Developmental delay
- ☐ Feeding/Eating problems
- ☐ Growth problems
- ☐ Hearing loss: Type _____
- ☐ Eye problems:

Type_____
- ☐ Neuromuscular defect
- ☐ Orthopedic problems
- ☐ Seizures:

Type_____
- ☐ Speech problem:

Type_____
- ☐ Spina bifida

Hematological (Blood-related)
- ☐ Anemia
- ☐ Bleeding (prolonged)
- ☐ Hemophilia
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Transfusion of blood

Infectious
- ☐ Hepatitis
- ☐ HIV infection (AIDS)
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease (STD)

Type_____

Substance use/Abuse
- ☐ Drug use
- ☐ Tobacco use
- ☐ Exposure to smoking
- ☐ Abuse (physical or sexual)
- ☐ Bullying

Other
- ☐ Cancer: Type _____
- ☐ Leukemia: Type _____
- ☐ Thyroid problem: Type _____
- ☐ Fainting/headaches (often)
- ☐ Sleep apnea
- ☐ Sleep problems
- ☐ Snoring
- ☐ Syndrome: Type _____
- ☐ Other: _____

If any boxes checked, please describe further: _____

_____

_____

2. Medications: Is your child CURRENTLY taking any medications including prescription and/or non-prescription drugs or vitamins? . . . . . Yes ☐ No ☐

Drug	How much & how often?	Reason

3. Steroid Use: Has your child had any steroid treatment in the past 6 months? . . . . . Yes ☐ No ☐

4. Allergies: Has your child had any known allergic reactions? . . . . . Yes ☐ No ☐

If yes to above, please list (please include any food or drug allergy): _____

_____

5. Development/Special needs:
Can your child talk and understand at his/her age level? . . . . . Yes ☐ No ☐
Does your child go to a special class or school? Yes ☐ No ☐ If yes, type: _____
Does your child use the following to help with walking? Wheelchair ☐ Walker ☐ Other ☐

6. Immunizations: Are your child's immunizations current? . . . . . Yes ☐ No ☐
If No to above, why _____

7. Have you ever been told that your child needs to take *antibiotics before dental treatment*? . . . . . Yes ☐ No ☐

8. Hospitalizations: Has your child ever been hospitalized? . . . . . Yes ☐ No ☐
If yes, reason for hospitalization? _____

9. Surgeries: Has your child had any surgery (operations)? . . . . . Yes ☐ No ☐
For what reason(s)? _____
Was your child put to sleep? . . . . . Yes ☐ No ☐
Were there any complications? If yes, please explain? _____ Yes ☐ No ☐

10. Have you or your child ever felt threatened in your home or are there any elevated stresses happening in your home? . . . . . Yes ☐ No ☐

DENTAL HISTORY

11. Why is your child here today? _____

12. If your child has been to a dentist previously:
When was last visit? _____ Have X-rays been taken? Yes ☐ No ☐ When: _____

13. How did your child react? _____

14. Has your child had local anesthesia ("Novocaine"?) . . . . . Yes ☐ No ☐
Were there any problems? _____

15. Is your child receiving/using any of the following below?
Fluoride tablets or fluoride multivitamins? . . . . . Yes ☐ No ☐
Fluoridated drinking water (community water fluoridation)? . . . . . Yes ☐ No ☐
Professional topical application (Fluoride rinse or gel)? . . . . . Yes ☐ No ☐

16. Brushing: Does your child brush his/her own teeth? . . . . . Yes ☐ No ☐
When does he/she brush? A.M. ☐ P.M. ☐ After meals ☐
Do you help in brushing your child's teeth? . . . . . Yes ☐ No ☐
Does your child use dental floss or do you floss your child's teeth? . . . . . Yes ☐ No ☐
What kind of toothbrush does he or she use? Hard ☐ Soft ☐ Battery Operated ☐
What kind of toothpaste does he or she use? _____; Does it contain fluoride? Yes ☐ No ☐ Unsure ☐

17. Diet: How many times per day does your child eat or have a snack? _____
What type of snacks? _____
How much and how often does your child usually drink per day of the following: Milk _____
Juice _____
Soda _____
Water _____

18. Trauma: Have your child's *teeth ever been injured*? . . . . . Yes ☐ No ☐

When (age)? _____

Which teeth? _____

Cause? _____

Did he/she receive treatment? . . . . . Yes ☐ No ☐

If yes, describe treatment _____

19. Habits: Does your child have any of the following habits? (Indicate what age range)

Bottle to sleep or nap containing _____ Yes ☐ No ☐

Thumb or finger sucking _____ Yes ☐ No ☐

Pacifier sucking _____ Yes ☐ No ☐

Mouth breathing _____ Yes ☐ No ☐

Grinding of teeth _____ Yes ☐ No ☐

20. Is there anything else you would like to tell us? _____

_____

_____ (Initials) I acknowledge that I have read and fully understand the Boston Children's Hospital Department of Dentistry's attendance policy

_____ _____ _____
Patient / Parent / Guardian Signature (If patient under 18 years of age) **Print** **Date**

_____
Relationship to patient

FOR COMPLETION BY DENTIST

Comments: _____

_____

_____

_____

_____

_____

Dentist Signature _____ _____ _____ _____
Print Name Date Time