



Child Personal and Health Questionnaire

Name: _____ (Nick Name) _____ S.S.N. _____ - _____ - _____
Gender: **M** or **F** D.O.B: _____ Age: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone:(____) _____ - _____ Mobile Phone:(____) _____ - _____ Email: _____
Mother's Full Name: _____ Father's Full Name: _____
How did you hear about our office: _____ Name of school: _____
Preferred Appointment Days: Mo: am pm Tu: am pm We: am pm Th: am pm Fr: am pm

Medical History

Have you ever been treated for: (Please circle **Y** for YES and **N** for NO)

Y / N Endocrine Problem Y / N Prolonged Bleeding Y / N Hepatitis Y / N Diabetes Y / N Arthritis
Y / N Nervous Disorder Y / N Heart Problems Y / N Cancer Y / N Liver Problems Y / N Asthma
Y / N Rheumatic Fever Y / N Bone Disorder Y / N Fainting Y / N Birth Defects Y / N AIDS/HIV
Y / N Allergies: (Please list) _____ Other conditions not listed: _____

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? _____ If so, which one: _____ Other medication(s): _____

Are you under the care of a physician? _____ If yes, why? _____

Dental History

Y / N Have you had prior orthodontic treatment?
Y / N Have there been any injuries to the face, mouth or teeth?
Y / N Do you have any problems with speech?
Y / N Have you been informed of any missing teeth?
Y / N Are any of your teeth sensitive or sore?
Y / N Do you have any cavities not filled?
Y / N Do you have any gum problems?

TMJ History

Y / N Do you clench and grind your teeth?
Y / N Has the jaw ever locked or slipped out of place?
Y / N Do you have frequent headaches?
Y / N Do you have pain or ringing in the ears?
Y / N Have you experienced any discomfort or clicking of the jaw

General Dentist: _____ Last Dental Cleaning: _____ How often do you brush: _____ Floss _____
Dentist's Address: _____ City: _____ State: _____ Zip Code: _____

Parent(Guardian) Information

Full Name: _____ Relationship to Pt: _____ Gender: M or F D.O.B: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone:(____) _____ - _____ Mobile Phone:(____) _____ - _____ Work Phone:(____) _____ - _____
SSN: _____ - _____ - _____ Email: _____
Marital Status: _____ Spouse's Full Name: _____
Employer: _____ Occupation: _____ Number of years employed: _____

Primary Dental Insurance Information

Do you have another Dental Insurance Policy for this child? Yes No

Policy Holder's Full Name: _____ SSN: _____ - _____ - _____ D.O.B: _____
Insurance Company: _____ Policy ID: _____ Group Number: _____
Insurance Company's Phone Number:(____) _____ - _____ Second Phone Number:(____) _____ - _____
Insurance Company Address: _____ City: _____ State: _____ Zip: _____
Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip Code: _____
Relationship to patient: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform the office of any changes to my child's medical status. If the office accepts my insurance, I am responsible for payment of any co-payment, deductibles or any fees that my insurance does not cover.

Parent/Guardian Signature: _____ Date: _____