CHILD HEALTH AND PERSONAL HISTORY UPDATE

PLEASE FILL OUT PRIOR TO EACH CLEANING APPOINTMENT

Child's Name_____ **Nickname**_____ **Date of Birth**_____

Child's primary residence is with: □ Mother □ Father □ Both □ Other

□ Yes □ No 1. Does your child have any current or previous medical concerns/problems? _____
_____

□ Yes □ No 2. Does your child have any allergies to medications, food or latex? If so, what? _____
_____

□ Yes □ No 3. Is your child taking any medications at this time? If so, what and why? _____

□ Yes □ No 4. Has your child **EVER** had surgery or been hospitalized? Why? _____

□ Yes □ No 5. Do you have well water?
Is your child taking fluoride supplements or using any prescription fluoride toothpaste? _____

□ Yes □ No 6. Do you have any questions or concerns regarding your child's oral health? _____
_____

□ Yes □ No 7. May we take bitewing x-rays (cavity detecting x-rays) on your child today, if needed?

□ Yes □ No 8. May we take a panoramic x-ray (growth & development x-ray) today, if needed?

□ Yes □ No 9. May we give your child a fluoride treatment? (May or May NOT be covered by Insurance)

□ Yes □ No 10. Does your child participate in any sports/physical activities? If so, does your child wear a mouth guard?
_____

Signature for treatment:_____Relation to child:_____ Phone _____

Date:_____