



DATE _____

CHILD'S NAME		NICKNAME		AGE	BIRTHDATE
SCHOOL	GRADE	RESIDENCE ADDRESS			ZIP
FATHER'S NAME		MOTHER'S NAME		PARENT'S TELEPHONE NUMBER (H) _____ (W) _____	
BROTHERS			SISTERS		
IF APPLICABLE, DENTAL INSURANCE CARRIER					
CHILD'S FAVORITE HOBBY		CHILD'S FAVORITE SPORT		ANY PETS?	

DENTAL HISTORY

	YES	NO		YES	NO
DATE OF LAST DENTAL VISIT _____			DOES YOUR CHILD BRUSH DAILY? _____	<input type="checkbox"/>	<input type="checkbox"/>
FOR WHAT _____			DO YOU ASSIST YOUR CHILD WITH BRUSHING? _____		
_____ BY DR. _____			HOW OFTEN _____	<input type="checkbox"/>	<input type="checkbox"/>
ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS? _____	<input type="checkbox"/>	<input type="checkbox"/>	IS DENTAL FLOSS USED? _____	<input type="checkbox"/>	<input type="checkbox"/>
HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS? _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE DISCLOSING TABLETS USED? _____	<input type="checkbox"/>	<input type="checkbox"/>
ANY INJURIES TO MOUTH, TEETH, HEAD? _____	<input type="checkbox"/>	<input type="checkbox"/>	HOW DOES YOUR CHILD RECEIVE FLUORIDE? <input type="checkbox"/> WATER SUPPLY <input type="checkbox"/> TOOTHPASTE		
ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING, MOUTHBREATHING, ETC.? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DENTIST <input type="checkbox"/> VITAMIN <input type="checkbox"/> TABLETS		
ANY LOST TEETH? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> NONE <input type="checkbox"/> OTHER _____		
			CHILD'S ATTITUDE TO DENTISTRY _____		

MEDICAL HISTORY

CHILD'S PHYSICIAN _____ ADDRESS _____ PHONE _____

DATE OF LAST COMPLETE PHYSICAL EXAMINATION? _____ RESULTS _____

	YES	NO
IS YOUR CHILD IN GOOD HEALTH? _____	<input type="checkbox"/>	<input type="checkbox"/>
IS YOUR CHILD PRESENTLY UNDER CARE BY A PHYSICIAN? _____	<input type="checkbox"/>	<input type="checkbox"/>
IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS? _____	<input type="checkbox"/>	<input type="checkbox"/>
WHAT IS YOUR CHILD'S WEIGHT _____ HEIGHT _____		
HAS YOUR CHILD EVER BEEN HOSPITALIZED? _____	<input type="checkbox"/>	<input type="checkbox"/>
HAS YOUR CHILD EVER HAD SURGERY? _____	<input type="checkbox"/>	<input type="checkbox"/>

EATING HABITS PRESENTLY - BRIEFLY EXPLAIN _____

ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION? _____

YES NO

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE
_____ | <input type="checkbox"/> | <input type="checkbox"/> | 9. ANEMIA OR BLOOD DISORDERS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CONGENITAL HEART DISEASE OR HEART MURMUR
_____ | <input type="checkbox"/> | <input type="checkbox"/> | 10. TUBERCULOSIS OR PNEUMONIA _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ALLERGIES: A) FOOD, DUST, ETC. _____ | <input type="checkbox"/> | <input type="checkbox"/> | 11. LIVER PROBLEMS, JAUNDICE OR HEPATITIS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| B) DRUG, i.e. Penicillin, etc. _____ | <input type="checkbox"/> | <input type="checkbox"/> | 12. GLANDULAR OR HORMONAL PROBLEMS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| C) UNKNOWN _____ | <input type="checkbox"/> | <input type="checkbox"/> | 13. ACCIDENTS OR SEVERE INFECTIONS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. ASTHMA OR HAY FEVER _____ | <input type="checkbox"/> | <input type="checkbox"/> | 14. CONVULSION, SEIZURES, FAINTING OR EPILEPSY
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS)
_____ | <input type="checkbox"/> | <input type="checkbox"/> | 15. HIGH/LOW BLOOD PRESSURE _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. DIABETES OR BLOOD SUGAR PROBLEMS _____ | <input type="checkbox"/> | <input type="checkbox"/> | 16. SPEECH, LEARNING, OR HEARING DISORDERS
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. ANY PROLONGED BLEEDING OR BRUISES EASILY
_____ | <input type="checkbox"/> | <input type="checkbox"/> | 17. CHILDHOOD ILLNESSES _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. KIDNEY OR BLADDER PROBLEMS _____ | <input type="checkbox"/> | <input type="checkbox"/> | 18. IMMUNIZATIONS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 19. OTHER, IF SO EXPLAIN _____ | <input type="checkbox"/> | <input type="checkbox"/> |

IF YES, PLEASE EXPLAIN _____

SUMMARY: (FOR DOCTOR'S USE)

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION DENTIST SHOULD BE AWARE OF THAT HAS NOT BEEN COVERED ABOVE.

HISTORY TAKEN FROM _____

SUBSEQUENT HISTORIES BY: _____	RELATIONSHIP _____	RECORDED BY _____	DATE _____
NAME _____	RELATIONSHIP _____	RECORDED BY _____	DATE _____
NAME _____	RELATIONSHIP _____	RECORDED BY _____	DATE _____
NAME _____	RELATIONSHIP _____	RECORDED BY _____	DATE _____
NAME _____	RELATIONSHIP _____	RECORDED BY _____	DATE _____

I hereby certify the foregoing information is correct and true. Because _____ is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Authorization is hereby granted as such.

Furthermore, I will be responsible for any professional fees incurred for dental services to my child.

I authorize CIGNA Dental Health or any participating dental office to release my child's dental records to any CIGNA company for plan administration purposes.

Signed _____ Date _____