Dr. Debra Chinonis | Child's History

Your child's name: ______ Nickname: ______ Birthdate: ______
Home address: ______
Street City State Zip

| Father's name: ______ | Mother's name: ______ |
|---|---|
| Employer: ______ | Employer: ______ |
| Work phone: ______ | Work phone: ______ |
| Home or Cell phone: ______ | Home or Cell phone: ______ |
| Address, if different than child: | Address, if different than child: ______ |

Person Responsible for the account: ______
**Primary insurance**: ______ Insured's name: ______
Contract # or ID ______ Phone # ______
Address ______ City ______ State ______ Zip ______
**Secondary Insurance**: ______ Insured's name: ______
Contract # or ID ______ Phone # ______
Address ______ City ______ State ______ Zip ______

What is the reason for your visit today? (Please check all that apply. Use the space below to explain.)

- o First visit to the dentist ______
- o Emergency ______
- o Transferring care ______
- o Specific problem ______
- o Pain ______

Whom may we thank for referring you to our office? ______

**Getting to know your child:**
Interests or hobbies? ______
Special pets or toys? ______
Siblings' names and ages? ______

Because your child is a minor, it is necessary that signed permission be obtained from the parent or guardian before any dental services can be rendered. Accordingly, please read the following statement carefully and sign below.

**I understand that the information I provide on this form is essential to determine my child's dental needs and for the provision of dental treatment in a safe, effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.**

**I authorize Dr. Chinonis and/or her staff to provide treatment for my child.**

______
**Signature of parent/guardian** **Date**

______
Relationship if not parent

I have reviewed the above information. ______
Doctor's Signature Date

**Your child's Dental History:**

Your child's previous dentist: ______________________ Telephone: ______________

Date of your child's last dental visit: ______________ Were x-rays taken? ______________

Please explain any "yes" answers in the blank area below:

YES NO Does your child have any dental problems now?

YES NO Do you have any concerns about your child's mouth?

YES NO Has your child had any difficulty with previous dental visits?

If so, what type of anesthesia was used?

- None
- Local anesthesia
- Nitrous oxide (gas)
- Sedation
- General anesthesia

YES NO Has your child ever worn orthodontic appliances?

YES NO Does your child snore?

YES NO Do your child's gums bleed or hurt?

YES NO Does your child experience pain from brushing or flossing?

YES NO Has your child ever had any broken teeth, injuries, or trauma to the mouth/face?

YES NO Do you assist your child with daily dental home care?

YES NO Was your child breast-fed?

If yes, for how long? ______________________

YES NO Was your child bottle-fed?

If yes, for how long? ______________________

Source of your child's drinking water? Please circle:

Bottled Purified Tap Well Other ______________

YES NO Is there fluoride in your water?

YES NO Has your child been given fluoride supplements or vitamins?

**Are your child's teeth sensitive to:**

YES NO Hot/COLD foods/drinks

YES NO Sweets

YES NO Biting/Chewing

**Does your child have a history of:**

YES NO Sucking thumb or fingers

YES NO Grinding teeth

YES NO Chewing or biting fingernails

YES NO Clenching jaw

YES NO Biting or sucking lips/cheeks

YES NO Mouth Breathing

YES NO Chewing hard objects

YES NO Bottle or pacifier habits

**Dietary Habits that may affect your child's dental health**:

YES NO Likes sweets

YES NO Chews gum

YES NO Snacks often

YES NO Drinks soda

YES NO Eats before bed

YES NO Dislikes fruits/vegetables

What are your child's favorite foods? ______________________

How often does your child brush their teeth? ______________________

How often does your child floss? ______________________

Please use this space to explain all "yes" answers: ______________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Your child's Medical History:**
Please explain any "yes" answer in the blank area below.
Your child's physician: ______________________________ Telephone: ______________
Address: ______________________________________________
Street City State Zip

Date of your child's last physical examination: ______________________________
YES NO Is your child currently under the care of a physician?
YES NO Have you ever been told your child needs antibiotics or pre-medication before dental treatment?
YES NO Has your child ever had an allergic reaction to medication? If so, please check and explain below:

- Local anesthetic ______________________________
- Penicillin (or other antibiotics) ______________________________
- Sulfa drugs ______________________________
- Aspirin ______________________________
- Barbiturates, sedatives, or sleeping pills ______________________________

YES NO Has your child ever had an allergic or adverse reaction to any other substance, medication or food?
If Yes, please describe: ______________________________
YES NO Is your child Current on their immunizations?
YES NO Does your child or anyone in your family have a history of acid reflux? If yes, whom? ______________
YES NO Has your child ever had a blood transfusion?
YES NO Does your child have a handicap or a special need?
If Yes, please describe: ______________________________

Please check which of the following conditions your child has or ever has had:
YES NO Abnormal bleeding
YES NO Acne medications
YES NO ADHD (Attention Deficit Hyperactivity Disorder)
YES NO AIDS/HIV positive
YES NO Allergies or Hives
YES NO Anemia
YES NO Asthma
YES NO Behavioral Issues
YES NO Cancer
YES NO Chicken Pox
YES NO Cardiovascular Disease
YES NO Cerebral Palsy
YES NO Congenital Heart Disease
YES NO Convulsions/Epilepsy/Seizures
YES NO Diabetes
YES NO Eating Disorders
YES NO Fainting Spells
YES NO Hayfever
YES NO Hearing Problems/Loss
YES NO Heart Murmur
YES NO Hemophilia
YES NO Hepatitis
YES NO Latex sensitivity
YES NO Measles
YES NO Mononucleosis
YES NO Mumps
YES NO Neurological disorders
YES NO Persistent Cough
YES NO Psychiatric/Psychological Issues
YES NO Rheumatic/Scarlet Fever
YES NO Speech Impediment
YES NO Stomach Problems
YES NO Tuberculosis

Please use this space to explain all "yes" answers: ______________________________
______________________________________________
______________________________________________
______________________________________________

Is your child taking any of the following:
YES NO Antibiotics or Sulfa drugs
YES NO Anticoagulants (blood thinners)
YES NO Aspirin
YES NO Cortisone or steroids
YES NO Dilantin or other anticonvulsants
YES NO Insulin or diabetic medications
YES NO Medicine for High Blood Pressure
YES NO Tranquilizers/sedatives
YES NO Other: ______________________

List any hospitalizations, surgeries, or serious illnesses and when:
______________________________ When? ______________
______________________________ When? ______________
______________________________ When? ______________
______________________________ When? ______________