CHILDREN'S HEALTH RECORD

Date________________

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointment, or fees, please feel free to ask. This acquaintance form will help us serve you better.

Child's Name____Social Security #______________________
(Last) (First) (Middle)

Home Address______________________________City______________State/Zip______Phone #____________

Date of Birth (DOB)__________Gender M / F___Height________Weight________Referred by____________________

Father's Name________________________DOB________Cell #______________Social Security #____________

Father's Address______________________________City______________State/Zip______Phone #____________

Father Employed By___________________________Address_______________________Phone #____________

Mother's Name________________________DOB________Cell #______________Social Security #____________

Mother's Address______________________________City______________State/Zip______Phone #____________

Mother Employed By___________________________Address_______________________Phone #____________

Type of Dental Insurance (If applicable)________________________________Policy #______________________

DENTAL HEALTH

Reason for visit______________________________ When was your last dental visit?____________________

Yes ☐ No ☐ Have you ever had any serious problem associated with previous dental treatment?
If Yes, explain:____
Yes ☐ No ☐ Is there any condition you feel your dentist should know about before undertaking treatment?
Please Describe ____
Yes ☐ No ☐ Do you clench or grind your jaws while sleeping or during the day?
Yes ☐ No ☐ Have you ever had a reaction to a dental injection?
Yes ☐ No ☐ Do your gums feel tender or swollen?
Yes ☐ No ☐ Do your jaws ever feel tired?
Yes ☐ No ☐ Do you smoke or use smokeless tobacco?
Yes ☐ No ☐ Do you have difficulty swallowing?
Yes ☐ No ☐ Have you noticed a change in the way your voice sounds?
Yes ☐ No ☐ Do you have any swelling in your jaw or neck?

All professional fees are due when services are rendered. If you are covered by a dental insurance plan, your percentage of fees and deductible must be paid at time of service.

NOTE: We do not bill absent parents. The adult presenting the minor for care is the responsible party.

Guardian's Signature:________________________

Eaglesoft Medical History(Custom)(3)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you smoke or use smokeless tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Are you currently taking any medications? ◯ Yes ◯ No
If yes, name medication and purpose.

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Jaw pain / grinding	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No	Taking a blood thinner	◯ Yes ◯ No	Infective endocarditis	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X________________________________ Date:__________