Child Medical Questionnaire

Child's Name:_______________________________ **Age:**_______ **Date of Birth:**___/___/_____

Parent's/Guardian's Name:_____________________________ **Phone Number:**____-____-______

Child's Address:____________________________ **City:**__________ **State:**______ **Zip:**______

Emergency Contact:__________________________ **Emergency Contact #:**________________

When was your child last seen by their Primary Care Doctor:__________ **What were the results:**________

Is your child being treated for anything at this time? Y / N **If yes, please describe:**__________________

Primary Care Doctor's Name:___________________ **Clinic Name:**_______________________

Please list any medications your child is currently taking:

Prescription/ Over-the-Counter: Vitamins/Supplements: Recreational:

Please List Any Allergies:____

<u>Do you know if, or has your child ever had any of the following:</u>

Y / N Abnormal Bleeding
Y / N Asthma
Y / N Behavioral/ Learning Disability
Y / N Diabetes
Y / N Dizziness
Y / N Cancer
Y / N Cerebral Palsy
Y / N Contact with HIV or AIDS Virus
Y / N Epilepsy
Y / N Eyesight Problems
Y / N Fainting Spells
Y / N Headaches
Y / N Hearing Loss
Y / N Hepatitis
Y / N Heart Valve Problems
Y / N Heart Murmur
Y / N Rheumatic Fever
Y / N Liver Disease
Y / N Jaundice
Y / N Kidney Infections
Y / N Psychiatric Care/Nervous Disorders
Y / N Speech Impairments
Y / N Thyroid Problems
Y / N Tuberculosis
Y / N Venereal Disease
Y / N Is your child currently pregnant
Y / N Does your child smoke

Please explain any recent hospitalizations or surgeries your child may have had:____________________

Child Dental Questionnaire

Is this your child's first visit to a dentist? Y / N If not, how long since last visit to a dentist?__________________

Were there any recent x-rays taken at your child's last dental visit? Y / N If so, when?_______________________

What is the main reason for bringing your child?____

How do you feel about the condition of your child's teeth? ____

How do you feel about your child's past dental experiences?____

Do you have any concerns, or questions about your child's dental treatment? ________________________________

Does your child receive fluoride? Y / N What kind of toothpaste does your child use?______________________

Has your child been instructed on how to brush/floss? Y / N How often does your child brush? _____*a day/a week*

How often does your child use dental floss? _____*a day/a week* Does your child eat or drink between meals? Y / N

Does your child now, or ever had any of the following:

Y / N Painful or sore areas on the gums
Y / N Toothaches
Y / N Injuries to teeth from falls or blows
Y / N Pain when chewing
Y / N Sensitivity to cold or hot
Y / N Regular Dental Check Ups
Y / N Any missing teeth
Y / N Offensive or bad breath
Y / N Canker Sores
Y / N Past cavities noted
Y / N Orthodontic treatment

Does your child's diet include any of the following (please circle):

Chewing Gum
Hard Candy
Breath Mints
Fruit Juice
Sports Drinks
Soft Drinks
Cookies / Pastries
Candy Bars

ATTENTION: In divorce situations, the parent that brings the child to the appointment is responsible for payment of all charges including co-pays, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

I HAVE READ THE JOHNSON CREEK DENTAL HIPAA PRIVACY RULE ACT (located by front desk)

Signature:____Date:________________

Signature of treating Dentist__________________________________Date:________________