Today's Date_____ (1)

Child Health History and Patient Information

Berthoud Family Dentistry

Carmen L Beckwith, DDS, PC

NAME_____ Prefer to be called _____ M or F Birth Date____/____/____ Age____

Child's Hm Address _____City_____Zip_____ Hm Phone _____

Mailing Address (if different than home address) _____

Child lives with: Both parents ___ Mother ___ Father ___ Other Guardian (please specify)_____

School _____ Grade____ Favorite Subjects _____

Hobbies/Sports/Interests_____

Please list other family members seen by us: _____

Who is accompanying your child today? _____ Relation _____

Whom can we thank for referring you? _____

***All minors must be accompanied by parent or guardian to receive treatment.**

***All of the following information must be completed and signed by parent or guardian. (front and back)**

Mother's Name _____Stepmother Guardian

Address _____Home Phone _____

Social Security#_____ Birth Date_____

Employer _____ Work Phone _____

E-mail Address _____ Cell/pager # _____

Father's Name _____ Stepfather Guardian

Address _____ Home Phone _____

Social Security #_____ Birth Date_____

Employer _____ Work Phone _____

E-mail Address _____ Cell/pager # _____

Parent's marital status: Married Divorced Separated Widowed Single

PERSON RESPONSIBLE FOR MAKING APPOINTMENTS? _____

PERSON RESPONSIBLE FOR ACCOUNT?_____
(if other than parent)
Billing Address_____ City _____ ST/Zip_____
Home Phone _____ Work Phone _____
Relationship _____Social Security # _____/_____/_____ Birth Date ____/____/_____
Employer _____

Dental Information

How often does your child see the dentist? _____ Date of last exam _____

What type of toothbrush does your child use? _____

Do you assist your child in brushing their teeth ?	Y N
Do your child's teeth ever cause discomfort?	Y N
Has your child ever had an upsetting dental experience?	Y N
Is there anything about dental treatment that bothers your child?	Y N

Please explain any 'Y' answers above _____

Is your child **Allergic** to any of the following?

Penicillin	Y	N	Nickel	Y	N
Latex	Y	N	Other metals or plastics	Y	N

Other Allergies: _____

If any of your answers are "Y", what happens when your child is exposed to the allergen? _____

Medical Information

Did/does your child have:

Any health problems.	Y	N
Ever been hospitalized	Y	N
Taking any medications	Y	N
Please list_____		
Abnormal delivery as infant. . . .	Y	N
Rheumatic fever, heart disease, Heart murmur.	Y	N
Asthma or respiratory problems	Y	N
Prolonged bleeding or anemia . .	Y	N
Thyroid or hormone therapy . . .	Y	N
Recurrent or chronic illness. . . .	Y	N
Organ transplants, joint replacement, Or ongoing health problems. . .	Y	N

Child's Physician:_____

Severe headaches	Y	N
Pain of head/face.	Y	N
Diabetes.	Y	N
Psychiatric counseling.	Y	N
Blood Transfusions.	Y	N
Hepatitis	Y	N
AIDS/HIV virus	Y	N
Mouth/lip lesions (sores). . . .	Y	N
Other infections.	Y	N
Epilepsy/seizures.	Y	N
Chemotherapy or radiation treatment	Y	N

Please explain any "Y" answers above _____

Are you required to pre-medicate before receiving dental treatment due to any of the above? Y N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

_____

Parent/Guardian/Responsible party Signature Date

Office Use Only

Reviewed HH with pt

Date_____ initial _____
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____

Premed's taken (if required)

date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____

Any Changes _____