Susan K. Blair, D.D.S.
Anupama Krishnamurthy, D.D.S.
Dhwani M. Joshi, D.M.D.

Children's Dentistry Group, LLC

# CONFIDENTIAL HEALTH HISTORY FORM

***Please fill out all applicable information completely.***

**Patient's Name: _____ Nickname: _____ Birthdate: _____**

**Residence/Street: _____ Home Phone: _____ Sex: _____**

**City: _____ State: _____ Zip Code: _____ E-mail: _____**

**Father's Name: _____ Employer: _____ SS#: _____**

**Cell Phone: _____ Work Phone: _____ Birthdate: _____ Marital Status: S / M / D / W**

**Mother's Name: _____ Employer: _____ SS#: _____**

**Cell Phone: _____ Work Phone: _____ Birthdate: _____ Marital Status: S / M / D / W**

**Elect to receive quarterly newsletter? Yes No (Please circle) Whom may we thank for referring you? _____**

---

## MEDICAL HISTORY

**Physician's Name: _____ Phone: _____**

**Address: _____ Date of Last Medical Exam: _____**

**Are your child's immunizations up to date? ☐ Yes ☐ No Is your child currently taking any medications? ☐ Yes ☐ No**

**Medications: (Please include dose & frequency)**

**_____**

**Significant injuries (such as head or teeth, broken bone, car accidents)? Please describe:**

**_____**

**_____Height: _____ Weight: _____**

## DOES THE PATIENT HAVE OR HAD ANY OF THE FOLLOWING?

**Please indicate with an (X)**

**Allergies (skin rashes, medication, food, dust, other _____)**
**Anemia or blood problems (Sickle Cell)**
**Arthritis/Joint pain**
**Asthma/Breathing problems**
**Bleeding problems**
**Bone or Muscular problems**
**Bronchitis**
**Cancer/other tumors**
**Cerebral Palsy**
**Chicken Pox**
**Diabetes**
**Ear/Hearing**
**Endocrine/Glandular problems**
**Eye/Vision problems**
**Handicaps (mental, physical, emotional)**
**Heart defects**
**Hepatitis/Jaundice**
**Immuno Suppressive (A.I.D.S.) Disease**
***Hospitalizations*:_____**
**_____**
**Kidney/Urinary Tract problems**

**Learning Disorders_____**
**Measles**
**Mumps**
**Nervous/Seizure problems**
**Pregnancy**
**Rheumatic Fever**
**Radiation Treatments**
**Scarlet Fever**
**Stomach/Digestive problems**
**Venereal Disease**

---

## DENTAL HISTORY

**Current Dentist's Name: _____Phone: _____**

**Address: _____Date of Last Dental Exam: _____**

**Has the patient had any unfavorable dental experiences? YES NO If yes, please explain: _____**

**Chief Oral Complaint:**
_____

### DOES THE PATIENT HAVE OF USE ANY OF THE FOLLOWING?
**Please indicate with an (X)**

**Traumatic injury to mouth or teeth**
**Sensitivity to cold/hot/sweet/pressure**
**Bleeding gums? How long_____**
**Food impaction**
**Clenching or grinding of teeth**
**Swelling or lumps in mouth**

**Frequent blisters on lips or mouth**
**Pain around the ears**
**Bad Breath**
**Complications from extractions**
**Topical Fluoride Treatment**
**Orthodontic Treatment or Supplements**
**Mouth breathing**

**Bedtime nursing bottle**
**Toothbrush texture_____**
**Brushing frequency _____**

**Dental Floss frequency _____**
**Disclosing tablets/solutions**
**Between meal snacks**
**Well-balanced diet**

**Oral habits: thumb sucking, nail biting, pacifier, cheek biting, tongue thrusting**

**Describe any current medical treatment including drugs taken, even though not listed above:**

_____

_____

**Is there anything that you feel Children's Dentistry Group should know about the patient?**

_____

***I certify that I have read and understand the above question. I will not hold Children's Dentistry Group, LLC responsible for any errors or omissions I may have made in completion of this form.***

**Signature of Person Completing Form:**

_____

**Relationship to Patient: _____ Date:**

_____