Boston Children's Hospital

LABEL OR PRINT
NAME **CHB MRN**

DOB **GENDER M F**

DENTAL PATIENT INFORMATION AND HEALTH HISTORY FORM
Department of Dentistry

Telephone: (617) 355-6571

In order to ensure that your child receive the best care at our clinic, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical records.

PATIENT INFORMATION AND HEALTH HISTORY

Child's Legal First and Last Name: _____ Child's Preferred Name: _____

Age: _____ Birthdate: _____ Sex:_____ Preferred Pronouns: _____

Child's Main Residential or
Mailing Address (could be PO Box): _____ City:_____ State: ____ Zip:_____

Home Telephone: _____

Guardian's Name: _____ Relationship to Child: _____

Cell: _____ Email: _____

Guardian 2's Name: _____ Relationship to Child: _____

Cell: _____ Email: _____

What is the best way to reach you? _____

What is the guardian's primary language? _____ The child's? _____

Date of Adoption, if applicable: _____

Were you referred to our clinic? Yes □ No □ If so, by who? _____

Whom may we call in case of emergency?

Name: _____ Relationship to Child: _____ Phone: _____

Child's Physician/Pediatrician: _____ Phone: _____

Mailing Address: _____ City:_____ State: _____ Zip:_____

Has the child been a patient at Children's Hospital Clinics in the past (or presently): Yes □ No □

Which clinic(s)? _____

Child's Previous Dentist: _____ Phone: _____

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Mailing Address: _____ City:_____ State: _____ Zip:_____

MEDICAL HISTORY

1. Medical conditions: Does your child have any history of the following? (*Check all that apply*)

General conditions
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Gastrointestinal disorders
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Rheumatic fever

Behavior/Learning
- ☐ ADHD/ADD
- ☐ Anxiousness/Nervousness
- ☐ Autism
- ☐ Behavior issues: Type_____
- ☐ Emotional problems:
  Type_____
- ☐ Learning problems:
  Type_____
- ☐ Psychiatric disorder:
  Type_____

Developmental
- ☐ Brain injury
- ☐ Cerebral palsy
- ☐ Cleft lip/palate
- ☐ Down Syndrome
- ☐ Developmental delay
- ☐ Feeding/Eating problems
- ☐ Growth problems
- ☐ Hearing loss: Type _____
- ☐ Eye problems:
  Type_____
- ☐ Neuromuscular defect
- ☐ Orthopedic problems
- ☐ Seizures:
  Type_____
- ☐ Speech problem:
  Type_____
- ☐ Spina bifida

Hematological (Blood-related)
- ☐ Anemia
- ☐ Bleeding (prolonged)
- ☐ Hemophilia
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Transfusion of blood

Infectious
- ☐ Hepatitis
- ☐ HIV infection (AIDS)
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease (STD)
  Type_____

Substance use/Abuse
- ☐ Drug use
- ☐ Tobacco use
- ☐ Exposure to smoking
- ☐ Abuse (physical or sexual)
- ☐ Bullying

Other
- ☐ Cancer: Type _____
- ☐ Leukemia: Type _____
- ☐ Thyroid problem: Type _____
- ☐ Fainting/headaches (often)
- ☐ Sleep apnea
- ☐ Sleep problems
- ☐ Snoring
- ☐ Syndrome: Type _____
- ☐ Other: _____

If any boxes checked, please describe further:

_____

_____

2. Medications: Is your child CURRENTLY taking any medications including prescription and/or non-prescription drugs or vitamins? Yes □ No □

Drug	How much & How often?	Reason

3. Steroid Use: Has your child had any steroid treatment in the past 6 months? Yes □ No □

4. Allergies: Has your child had any known allergic reactions? Yes □ No □
If yes, please list (please include any food or drug allergy):

_____

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5. Development/Special Needs:
Can your child talk and understand at their age level? Yes □ No □

Does your child go to a special class or school? Yes □ No □
If yes, type: _____

Does your child use the following to help with walking? Wheelchair □ Walker □ Other □

6. Immunizations: Are your child's immunizations current? Yes □ No □
If no, why? _____

7. Have you ever been told that your child needs to take antibiotics before dental treatment? Yes □ No □

8. Hospitalizations: Has your child ever been hospitalized? Yes □ No □
If yes, reason for
hospitalization(s):_____

9. Surgeries: Has your child had any surgery (operations)? Yes □ No □
For what reason(s): _____

Was your child put to sleep? Yes □ No □

Were there any complications? Yes □ No □
If yes, please explain:_____ _____

10. Have you or your child ever felt threatened in your home or are there any elevated stresses happening in your home?
Yes □ No □

DENTAL HISTORY
1. Why is your child here today? _____

2. If your child has been to a dentist previously:

When was the last visit? _____ Have X-rays been taken? Yes □ No □ When:_____

3. How did your child react? _____

4. Has your child had local anesthesia ("Novocaine")? Yes □ No □
If so, were there any problems? _____

5. Is your child receiving any of the following below:
Fluoride Tablets or fluoride multivitamins? Yes □ No □
Fluoridated drinking water (community water fluoridation)? Yes □ No □
Professional topical application (fluoride rinse or gel)? Yes □ No □

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6. Brushing: Does your child brush their own teeth? Yes □ No □

When do they brush? AM □ PM □ After meals □

Does the child receive help when brushing their teeth? Yes □ No □

Does your child use dental floss? Yes □ No □

What kind of toothbrush does your child use? Hard □ Soft □ Battery Operated □

What kind of toothpaste does your child use? _____
Does it contain fluoride? Yes □ No □ Unsure □

7. Diet: How many times per day does your child eat or have a snack? _____
What type of snacks?_____

How much and how often does your child usually drink per day of the following:
Milk_____ Juice_____ Soda_____ Water_____

8. Trauma: Have your child's teeth ever been injured? Yes □ No □
If yes, when (age)? _____ Which teeth? _____ Cause?_____
Did your child receive treatment? Yes □ No □
If yes, describe treatment:_____

9. Habits: Does your child have any of the following habits?
Bottle to sleep or nap containing Yes □ No □ If yes, age range:_____
Thumb or finger sucking Yes □ No □ If yes, age range:_____
Pacifier sucking Yes □ No □ If yes, age range:_____
Mouth breathing Yes □ No □ If yes, age range:_____
Grinding of teeth Yes □ No □ If yes, age range:_____

10. Is there anything else you would like to tell us?
_____
_____

---------- FOR COMPLETION BY DENTIST ----------

Comments:
_____
_____

Dentist Signature: _____ Print Name: _____

Date: _____ Time: _____