MINOR PATIENT HEALTH QUESTIONNAIRE

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Tell Us About Your Child

Today's Date:________________

Name: ____
(LAST) (FIRST) (M.I.)

Child's Nickname: ________________ Male Female

Child's Birth Date: __/___/_____ Child's Age:_________

Phone: (___) _____-________ SSN: ____-_____-_______

Child's Address:____________________________________

City:_________________State:_______ Zip:__________

Other Family Members Seen In Our Office: ______________

____

Previous or Present Dentist:_________________________

Last Visit: ______________ Last Exam:_______________

Who is Accompanying the Child?

Name: ____
(LAST) (FIRST) (M.I.)

Relation:______________ Legal Guardian: ☐ Yes s No

Work Phone: (_____) _______-________ Ext.: _________

SSN: ______–_____–______ Birth Date: _____/____/_____

Tell Us About Your Child

Parent's Marital Status: : S ☐ M Div. ☐ Widowed ☐ Sep.

FATHER

Name:____

Wk Phone: ___________Ext. ____ Hm Phone: ____________

Employer: ______________________________________

SSN: ______–___–______

MOTHER

Name:____

Wk. Phone:___________ Ext. ____ Hm. Phone: __________

Employer:______________________________________

SSN: _______–___–______

Which parent is responsible for making appts.? _____________

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DUE TO MEDICO-LEGAL REASONS, NO MINOR WILL BE SEEN IN OUR OFFICE WITHOUT A PARENT OR LEGAL GUARDIAN BEING PRESENT THROUGHOUT THE VISIT. HIPPA LAWS AND CONSENT LAWS REQUIRE SUCH. IF WE DISCOVER A MINOR IS UNACCOMPANIED AT ANYTIME DURING TREATMENT, SUCH TREATMENT WILL BE STOPPED IMMEDIATELY AND THE MINOR PATIENT DISMISSED.

X_________________________________ Date:__________

Dental Insurance Info.

PRIMARY POLICY

Insurance Comp. Name:______________________________

Group # (Plan or Policy#): ___________________________

Insured's Name:_________________Relationship:_______

Member #:____

Insured's B-day: ___/___/_____ SSN: ____–____–_________

Insured's Employer:__________________________________

SECONDARY POLICY

Insurance Comp. Name:______________________________

Group # (Plan or Policy#): ___________________________

Insured's Name:_________________Relationship:_______

Member #:____

Insured's B-day: ___/___/_____ SSN: ____–____–_________

Insured's Employer:__________________________________

Why did you bring the child?

Has the child ever had a serious or difficult problem with dental appointments or medical appointments? ☐ Yes No

Is your child having dental pain or mouth pain? ☐ Yes No

Does the child have speech problems? ☐ Yes No

Is there concern over smile appearance? ☐ Yes No

Is there concern over breath odor? ☐ Yes No

Is the child's water fluoridated? Yes e No

Is the child taking fluoride supplements? ☐ Yes No

Does the child brush their teeth daily? ☐ Yes No

Does the child floss their teeth daily? ☐ Yes No

Has your child reached puberty? ☐ Yes No

Does the Child have any of the following habits:

- Thumb, finger-sucking or Pacifier ☐ Yes No
- Lip Sucking / Biting? ☐ Yes No
- Nail Biting? ☐ Yes No

Has your child been seen by an Orthodontist? ☐ Yes No

Does your child have any learning disabilities? ☐ Yes No

Does your child have any dev. disabilities? ☐ Yes No

Does your child consume mostly sugared drinks? ☐ Yes No

Is child a regular snack eater between meals? ☐ Yes No

Is child excessively anxious about dental work? ☐ Yes No

Patient Name: ______________________________ Date: ______________ Age: __________

MEDICAL HISTORY OF YOUR CHILD

1. Has your child been under the care of a medical doctor during the past two years? ….……………………… ☐ Yes ☐ No

If yes, please list doctor, condition, treatments and dates:

Doctor's Name	Condition/Treatment	Date

2, Please list all medications your child has taken in the last six months: ______________________________

____

____

3. Is your child sensitive or allergic to any medication? ……………………………………………………… . Yes ☐ No

If yes, please list known drug allergies:______________________________

Please circle any of the follow your child is allergic to: PENICILLIN ASPIRIN CODEINE ERYTHROMYCIN CLINDAMYCIN TETRACYCLINE

4. Female Patients Only: Is your daughter pregnant? ……………………………………………………… . Yes . No

Is your daughter taking birth control pills? ………………………………………. ☐ Yes ☐ No

5. Has a physician ever told you that your son or daughter needs to pre-medicate with an antibiotic before surgery? ☐ Yes s No

6. Has your child received all of their childhood vaccinations in accordance with their physician's direction? Yes Y No

Please circle any of the following conditions which your child has been diagnosed with by a physician:

Cardiovascular (Heart/Circulation)

1. Heart Murmur
2. Rheumatic Fever
3. Mitral Valve Prolapse
4. Artificial Heart Valve
5. High Blood Pressure (Hypertension)
6. Low Blood Pressure
7. Heart Disease
8. Angina Pectoris
9. Heart Pacemaker
10. Heart Surgery

Kidney & Liver

1. Liver Disease
2. Kidney Trouble
3. Excessive Bleeding
4. Hepatitis A Hepatitis B Hepatitis C
5. Jaundice
6. G.I. Disorder: (Crone's Dz., Diverticulitis, IBS, etc.)

Neurological

1. Migraines
2. Autism
3. Epilepsy / Seizures

Miscellaneous

1. Artificial Joint
2 Cancer or Tumor
3. Leukemia
4. Chemotherapy or Radiation Therapy
5. Anemia
6. Hemophilia
7. Bleeding Disorders
8. Tuberculosis
10. HIV, AIDS
11. Diabetes: Type 1 Type 2
12. Sinus Problems / Infections
13. Thyroid Disease
14. Arthritis
15. Psychiatric Treatment (depression, anxiety, etc.)
16. Venereal Diseases (syphilis, gonorrhea, herpes, etc.)
17. Organ removal or Transplant
18. Vision Problems, Blindness
19. Urinary Tract Infections / Anomalies
20. Temporomandibular Joint Dysfunction (TMJ)
21. Attention Deficit Disorder (ADD)
22. Attention Deficit Hyperactivity Disorder (ADHD)
23. Precocious Puberty or Delayed Puberty
24. Hormonal Therapy
25. Tooth Grinding
26. Trauma to face or to the teeth

To the best of my knowledge, all of the preceding answers to this questionnaire are true and correct. If my child has any changes in their health or medications, I will notify this office at the next appointment without fail.

______________________________ (SIGNATURE OF OF PARENT OR GUARDIAN) ______________ (DATE) ______________________________ (SIGNATURE OF DENTIST)

Med Update 1: __________ by ______ on: ____/___/_____ Med Update 2: ___________by _______ on: _____/____/_____

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