



CHILD AND TEEN HEALTH QUESTIONNAIRE

In order to render optimum health care service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore **PLEASE ANSWER EVERY QUESTION.**

PERSONAL INFORMATION

Date_____

Child's Full Name _____ Nickname _____

Address _____ Home phone _____

City _____ Postal Code _____

Age _____ Birthdate _____ Grade _____ School _____

Father's Name _____ business phone _____

Mother's Name _____ business phone _____

parents e-mail address _____

Name of person responsible for this account _____

Do you have dental insurance? Yes ___ No ___

Name of Policy Holder _____

Employer's Name _____

Insurance Company _____

Group# _____ Certificate or Subscriber ID# _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Child's Physician _____ Tele. No. _____

Has your child been under the care of a doctor or clinic within the last 6 months for any treatment or observation? Yes ___ No ___

Is your child now taking or receiving any drugs or medications? Yes ___ No ___

If so, name drug(s) and dosages _____

Has your child ever had or been treated for (please circle):

- | | | | |
|--------------------------|--------------|------------------------------|-------------------------|
| rheumatic fever | heart murmur | heart trouble | stroke |
| abnormal blood pressure | jaundice | hepatitis | liver disease |
| kidney disease/infection | diabetes | psychiatric/mental disorders | |
| epilepsy | cancer | ulcers | A.I.D.S or HIV positive |

Has your child ever had an operation or any other serious illness other than the above? Yes ___ No ___

If yes, explain _____

Does your child have asthma, hay fever or hives? Yes ___ No ___

Is your child allergic to anything? Please list _____

Parents Consent for children under 18

I hereby consent to the performing of Dental and Oral Surgery Procedures necessary or advisable for my children, including the use of Local Anesthetic or Relative Analgesia, as indicated, and I accept responsibility for the fee.

Parent's Signature _____ **Date** _____
