

Children's Pre-Clinical History



Date: _____

Child's Name: _____

Nickname: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

School: _____ Grade: _____

Date of Birth: _____ Age: _____

Names/ages of brothers/sisters: _____

Father's Name: _____

Social Security #: _____

Employer: _____

Address: _____

Home phone: _____ Business phone: _____

Name of dental insurance company: _____

Policy #: _____

Address of dental insurance company: _____

Mother's Name: _____

Social Security #: _____

Employer: _____

Address: _____

Home phone: _____ Business phone: _____

Name of dental insurance company: _____

Policy #: _____

Address of dental insurance company: _____

Whom may we thank for referring you to our office? _____

Is this your child's first dental experience? yes no

What is your child's attitude toward this visit? _____

(continued on other side)



How has your child responded to past visits to the physician and/or dentist?

- very well moderately well moderately poor very poorly

How would you rate your own anxiety (fear, nervousness) at this moment?

- high moderately high moderately low low

Does your child think there is anything wrong with his or her teeth, such as a chipped tooth, decayed tooth, gumboil, etc.?

- yes no

How do you expect your child to behave in the dental chair? very well moderately well moderately poor very poorly

Child's favorite sport? _____ Favorite toy? _____

Favorite hobby? _____

Is your child in good health? yes no

When was your child's last medical exam? Date _____ Year _____

Has your child required hospitalization or had a serious illness? yes no

If yes, please explain: _____

Are your child's immunizations up-to-date? yes no

Is your child sensitive/allergic to anything? yes no

If yes, please explain: _____

Is your child presently taking any medications? yes no

If yes, please explain: _____

Please check any of the following that apply to you:

- Rheumatic fever Asthma Diabetes Counseling
- Heart murmur Hay fever Breathing disorders Mitral valve prolapse
- Epilepsy Anemia Hearing impairment Visual impairment
- Attention disorder Other _____

Is there any additional information that you feel would be helpful in meeting your personal needs?: _____

Signature _____ Date _____

