# Child Health History

This personal information will help us to give you the most consideration of your time and feelings.
It is most important to have complete answers. All of the information is, of course, confidential.

Date_____ Alternate Parent(s) Phone – Cell: (____)_____

Childs Name _____ Date of Birth _____

Home address (include city & zip) _____

Home phone _____ School _____ Grade _____

Mothers name _____ Occupation _____

Employer _____ Phone _____

Fathers name _____ Occupation _____

Employer _____ Phone _____

Responsible person (if other than parent) _____

Is the child covered by dental insurance? _____ If so, what insurance _____

Are you aware of your child having and particular dental problems? _____

Is your child having any discomfort or pain? _____

Is this your child's first visit to a dental office? _____ If not, how long since the last exam _____

What was done for your child at that time? _____

| Has your child ever had: | YES | NO | |
|---|---|---|---|
| Rheumatic fever? | _____ | _____ | |
| Any kind of Heart problem? | _____ | _____ | If so, what _____ |
| Diabetes | _____ | _____ | |
| Asthma | _____ | _____ | If so, what medication _____ |
| Hay Fever | _____ | _____ | If so, what medication _____ |
| Sensitive or Allergic to Penicillin | _____ | _____ | |
| Codeine | _____ | _____ | |
| Novocaine | _____ | _____ | |
| Aspirin | _____ | _____ | |
| Anesthetics | _____ | _____ | |
| Food | _____ | _____ | If yes, what kind _____ |

Name of child's Physician _____ Last check up _____

Is your child under a physician's care now? _____ If so, for what _____

Any other medical condition or medications not listed _____

_____

*I hereby give the office of Dr. Nancy Arndt permission for an Exam, Prophylaxis (cleaning) and X-rays if due.*

Parent's Signature _____