Child Health & Dental History Form

WELCOME

Welcome to the practice of Dr. Robert Golia. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

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PATIENT INFORMATION

Last Name | First Name | M.I. | Nickname | Sex | Birthdate

Parent/Guardian's Name | Relationship

Address | City | State | Zip | Date (10/12/15)

Home Phone | Work Phone | Cell Phone

How would you prefer we confirm your child's appointment? (Ctrl to select mutiple)

Home Phone
Work
Cell
Email

Email

Name of child's physician | Phone Number

Where did you hear about us?

Which pharmacy do you use? | Phone Number

HEALTH INFORMATION

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ○ Yes ○ No

1. Active Tuberculosis 2. Persistent cough greater than a three-week duration 3. Cough that produces blood

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other (write below)
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle Cell	

Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ○ Yes ○ No

If yes, please list:

Is the child allergic to any medications (i.e., penicillin, antibiotics or other drugs)? ○ Yes ○ No

If yes, please list:

Is the child allergic to anything else, such as certain foods? ○ Yes ○ No

If yes, please list:

HEALTH INFORMATION (Continued)

How would you describe the child's eating habits?

Has the child ever had a serious illness? ○ Yes ○ No When?

Please Describe:

Has the child ever been hospitalized? ○ Yes ○ No

Does the child have a history of any other illnesses, or is the child currently being treated for any illnesses? ○ Yes ○ No

If yes, please describe:

Has the child ever received a general anesthetic? ○ Yes ○ No

Does the child have any inherited problems? ○ Yes ○ No

Does the child have any speech difficulties? ○ Yes ○ No

Has the child ever had a blood transfusion? ○ Yes ○ No

Is the child physically, mentally or emotionally impaired? ○ Yes ○ No

Does the child experience excessive bleeding when cut? ○ Yes ○ No

Is this the child's first visit to a dentist? ○ Yes ○ No If not, date of last dental visit:

Has the child had any problem with dental treatment in the past? ○ Yes ○ No

Has the child ever had dental radiographs (x-rays) exposed? ○ Yes ○ No

Has the child ever suffered any injuries to the mouth, head or teeth? ○ Yes ○ No

Has the child had any problems with the eruption or shedding of teeth? ○ Yes ○ No

Has the child had any orthodontic treatment? ○ Yes ○ No

What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water

Does the child take fluoride supplements? ○ Yes ○ No

Is fluoride toothpaste used? ○ Yes ○ No

How many times are the child's teeth brushed per day? When are the teeth brushed?

Does the child suck his/her thumb, fingers or pacifier? ○ Yes ○ No

At what age did the child stop bottle feeding? Age: Breastfeeding? Age:

Does the child participate in active recreational activities? ○ Yes ○ No

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold **Dr. Golia** or any member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

Parent/Guardian Signature

Date