2/11/20

Access COMMUNITY HEALTH CENTERS

CHILD HEALTH QUESTIONNAIRE

In order to provide a complete dental exam for your child, please answer the following questions as completely as possible.

Patient Name:	DOB:	Sex:
Address:		Phone:
Preferred Name:	SSN:	Age:
Choose all that apply: ☐ Caucasian/White ☐ African American/Black ☐ Hispanic/Latino ☐ American Indian/Eskimo ☐ Southeast Asian ☐ Hawaiian/Pacific Islander ☐ Other Asian ☐ Decline		
Father's Name:	Mother's Name:	
Is Child adopted: ☐ No ☐ Yes	Legal Guardian's Name:	

MEDICAL HISTORY

Child's Physician:	Physician Phone:
Date of last Physical exam:	
How is your child's general health?	
Has your child had any serious illness? ☐ No ☐ Yes If yes, please describe:	
Has your child ever been hospitalized? ☐ No ☐ Yes If yes, please describe:	
Is your child receiving any medications currently? ☐No ☐Yes If yes, please list:	
Has your child ever had an allergic reaction to the following: (check all that apply) ☐ None ☐ Dental Anesthetics ☐ Food ☐ Antibiotics ☐ Drugs ☐ Latex Other, please describe:	
Has your child ever received a blow or injury to their head or teeth? ☐ No ☐ Yes If Yes, please describe:	
Has your child ever been treated with X-ray or Radiation therapy? ☐ No ☐ Yes	

Has your child ever had any of the following conditions? Check all that apply

Condition	√ if Yes	Age	Condition	√ if Yes	Age	Condition	√ if Yes	Age
Heart Murmur			Bleeding Problems			Hearing problems		
Rheumatic Fever			Lung Disease			TB(Tuberculosis)		
Diabetes			Liver Disease			Learning Disability		
Scarlet Fever			AIDS or HIV			Sickle Cell Anemia		
Kidney Disease			Emotional Problems			Epilepsy		
Asthma			Monucleosis			Hepatitis C		
Hepatitis A			Hepatitis B			Other:		

DENTAL HISTORY

Does your child have any habits we should know about, such as: ☐ Poor eating habits ☐ Thumb sucking ☐ Pacifier ☐ Bottles ☐ Other:
Does your child receive fluoride in drinking water at home? ☐ No ☐ Yes By prescription? ☐ No ☐ Yes
Has your child had any unpleasant dental experience? ☐ No ☐ Yes If yes, How can we help?
Date of last dental examination:
Has your child ever had orthodontic treatment? ☐ No ☐ Yes When:

--OVER--

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I understand the above information is necessary to provider my child with dental care in a safe and effective manner. I have answered all questions to the best of my knowledge. Should further information be need you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my child's health or medication. I also grant permission for x-rays, examination and diagnostic procedures necessary for my dental provider to make a diagnosis and treatment plan.

I hereby authorize my child's dentist and whom he/she may designate as his/her assistants and/or hygienists to perform an initial oral evaluation, take the necessary x-rays and perform the appropriate diagnostic tests in order to establish a treatment plan for my child's dental care. I am informed and fully understand that there are certain risks in any dental treatment. These risks included but are not limited to mild pain, sensitivity of teeth and gums and bleeding of the gums. No procedure will be performed on my child without my permission.

Signature of Parent or Guardian: _____ Date: _____

Dentist/Provider signature: _____ Date: _____