232 W. 61st Street
New York, NY 10023
toothworksnyc.com

Office: 646-558-6058
Fax: 646-558-6059
info@toothworksnyc.com

Child Health/Dental History Form

Child's Name: LAST FIRST | Nickname: | Date of Birth: / /

Address: STREET ADDRESS AND APT # CITY STATE ZIP | Gender: Male Female

Parent 1 info: mother father legal guardian NAME PHONE | Parent 2 info: mother father legal guardian NAME PHONE

Email address (for appointment reminders): | How did you hear about our office?

check here if same as sibling already at practice

Dental Insurance Co. Name: ID #: Group #:

Primary insured (from above): Parent 1 Parent 2 Date of Birth: SSN:

Please list the name and number of your child's pediatrician as well as any frequently seen specialists, if applicable:

Name of pediatrician: ______________________ Number: ______________

Name of alternate physician/specialist: ______________________ Number: ______________

Please review **carefully** and check (☑) if your child has any history of, or condition related to, any of the following:

Anemia	Cancer	Epilepsy/Seizures	Latex Allergy	Sickle Cell Anemia	STD
Arthritis	Cerebral Palsy	Fainting	Liver/Hepatitis	Snoring	Vision disorders
Asthma	Chicken Pox	Growth Problems	Measles	Speech/Hearing	Other (write below):
Autism	Chronic Sinusitis	Headaches	Mononucleosis	Skin	
Bladder/Kidney	Diabetes	HIV+/AIDS	Mumps	Thyroid	
Bleeding disorders	Ear Aches/Infection	Hyperactivity	Pregnancy (teens)	Tobacco/Drug Use	
Bone disorders	Enlarged tonsils	ADHD/ADD	Rheumatic Fever	Tuberculosis	NONE

YES NO

Please complete the following health/dental questionnaire:

1. Is your child taking any medications (prescription, over-the-counter, vitamin supplements)?
   Please list all: ______________________
2. Is your child allergic to any of the following? Please explain details if YES:
   Medication allergies? ______________________
   Food allergies? ______________________
   Metal allergies? ______________________
   Seasonal or other? ______________________
3. Has your child been hospitalized or had any surgery? Please explain: ______________________
4. Has your child ever received sedation or general anesthesia? ______________________
5. If YES to #4, were there any complications? Please explain: ______________________
6. Does your child have any mental, developmental, or physical impairments?
   Please explain: ______________________
7. Has your child ever experienced excessive bleeding when cut or injured?
8. Does your child have any genetic or inherited disorders?
   Please explain: ______________________
9. Is your child being treated for any other illnesses not yet discussed on this form?
   Please explain: ______________________
10. Are your child's immunizations up to date? If NO, please explain:______________________

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YES NO

11. Is this your child's first dental visit? If not, date of last visit? ______________________________
12. Have there been any injuries to your child's mouth, teeth, or head?
    Please explain when/how: ______________________________
13. How often are your child's teeth brushed per day? _________ Time(s) of day? AM PM Mid-day
14. Brushing is: done by an adult supervised none of the above (child brushes alone)
15. Is fluoride toothpaste used?
16. Does your child participate in any sports or other recreational activities? ______________________________
17. Has your child complained of any recent dental pain? Please explain: ______________________________
18. Are there any other concerns not yet discussed on this form?
    ____

Habit and Dietary Questionnaire:

- **Breast-feeding:** past; age when stopped: current; times per day? never
- **Bottle use:** past; age when stopped: current; contents: never
- **Sippy cup use:** straw spout not used
- **Pacifier use:** past; age when stopped: current never
- **Thumb/finger sucking:** past, age when stopped: current never

Please indicate the level of consumption for each of the items below:

- **Juice intake:** daily 1-2 times per week rarely/never
- **Flavors in milk (i.e. - chocolate, vanilla, strawberry, etc.):** daily 1-2 times per week rarely/never
- **Sticky foods (i.e. - dried fruits, fruit snacks, etc.):** daily 1-2 times per week rarely/never
- **Carb-rich snacks (i.e. - chips, cookies, crackers, etc.):** daily 1-2 times per week rarely/never
- **Does your child have any food/milk after brushing at night?** regularly 1-2 times per week rarely/never

As this child's parent or legal guardian, I acknowledge that the completed information in this form is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment. Additionally, I have read the office policies and agree to abide by them.

______________________ Parent/Legal Guardian Signature
______________________ Print Name
______________________ Today's Date

Office Use Only

______________________ Dentist Signature
______________________ Name