

# 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:

- |  |                                   |   |   |
|--|-----------------------------------|---|---|
| <input type="radio"/> Rheumatic fever    | <input type="radio"/> Asthma      | <input type="radio"/> Diabetes            | <input type="radio"/> Counseling            |
| <input type="radio"/> Heart murmur       | <input type="radio"/> Hay fever   | <input type="radio"/> Breathing disorders | <input type="radio"/> Mitral valve prolapse |
| <input type="radio"/> Epilepsy           | <input type="radio"/> Anemia      | <input type="radio"/> Hearing impairment  | <input type="radio"/> Visual impairment     |
| <input type="radio"/> Attention disorder | <input type="radio"/> Other _____ |   |   |

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

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_