Boston Children's Hospital

Use Plate, Label, or Print:
Name:
BCH MRN#:
DOB: Gender: M F

DENTAL PATIENT INFORMATION AND HEALTH HISTORY FORM

Department of Dentistry Telephone: (617) 355-6571

In order to ensure that your child receive the best care at our clinic, we ask you to carefully complete this form.

PATIENT INFORMATION AND HEALTH HISTORY

Child's Legal First and Last Name: ____________________ Child's Preferred Name: ____________

Age: _____ Birthdate: ____________ Sex:________ Gender:_________ Preferred Pronouns: ____________

Guardian's Name: ______________________ Relationship to Child: ____________

Phone: ____________ Email: ______________________

Guardian 2's Name: ______________________ Relationship to Child: ____________

Phone: ____________ Email: ______________________

Were you referred to our clinic? Yes □ No □ If yes, by whom? ______________________

MEDICAL HISTORY

1. Medical conditions: Does your child have any history of the following? (*Check all that apply*)

General conditions

- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Gastrointestinal disorders
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Rheumatic fever

Behavior/Learning

- ☐ ADHD/ADD
- ☐ Anxiousness/Nervousness
- ☐ Autism
- ☐ Behavior issues: Type________
- ☐ Emotional problems: Type____________
- ☐ Learning problems: Type____________
- ☐ Psychiatric disorder: Type____________

Developmental

- ☐ Brain injury
- ☐ Cerebral palsy
- ☐ Cleft lip/palate
- ☐ Down Syndrome
- ☐ Developmental delay
- ☐ Feeding/Eating problems
- ☐ Growth problems
- ☐ Hearing loss: Type ________
- ☐ Eye problems: Type____________
- ☐ Neuromuscular defect
- ☐ Orthopedic problems
- ☐ Seizures: Type____________
- ☐ Speech problem: Type____________
- ☐ Spina bifida

Hematological (Blood-related)

- ☐ Anemia
- ☐ Bleeding (prolonged)
- ☐ Hemophilia
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Transfusion of blood

Infectious

- ☐ Hepatitis
- ☐ HIV infection (AIDS)
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease (STD) Type____________

Substance use/Abuse

- ☐ Drug use
- ☐ Tobacco use
- ☐ Exposure to smoking
- ☐ Abuse (physical or sexual)
- ☐ Bullying

Other

- ☐ Cancer: Type ____________
- ☐ Leukemia: Type ____________
- ☐ Thyroid problem: Type ________
- ☐ Fainting/headaches (often)
- ☐ Sleep apnea
- ☐ Sleep problems
- ☐ Snoring
- ☐ Syndrome: Type ____________
- ☐ Other: ____________

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2. Medications: Is your child CURRENTLY taking any medications and/or vitamins? If yes, what? ____________________________

3. Steroid Use: Has your child had any steroid treatment in the past 6 months? Yes □ No □

4. **Antibiotics**: Have you ever been told that your child needs to take antibiotics before dental treatment? Yes □ No □

5. Allergies: Has your child had any known allergic reactions? Yes □ No □
If yes, please list (please include any food or drug allergy):
____

6. Hospitalizations: Has your child ever been hospitalized? Yes □ No □
If yes, reason for hospitalization(s): ____

7. Surgeries: Has your child had any surgery (operations)? Yes □ No □
For what reason(s): ____
Were there any complications? Yes □ No □
If yes, please explain:____

8. Have you or your child ever felt threatened in your home or are there any elevated stresses happening in your home? Yes □ No □

DENTAL HISTORY

1. Why is your child here today? ____

2. If your child has been to another dentist previously:
Dentist Name: _____________________ Date of last visit: _____________________
Have X-rays been taken? Yes □ No □ When: _____________________

3. Brushing: Does your child brush their own teeth? Yes □ No □
When do they brush? AM □ PM □ After meals □
Does your child use dental floss? Yes □ No □
What toothpaste does your child use? ________________________________ Does it contain fluoride? Yes □ No □

4**. Diet**: How many times per day does your child drink? Water ___ Milk ___ Juice ___ Sports drinks ___ Soda ___ Other _______
How many times per day does your child snack? _____ What types of snacks? ____

4. Trauma: Have your child's teeth ever been injured? Yes □ No □
If yes, when (age)? _______________ Which teeth? _________________ Cause?_______________________________________
Did your child receive treatment? Yes □ No □
If yes, describe treatment:____

5. Habits: Does your child have any of the following habits?
Bottle to sleep or nap Yes □ No □ Mouth breathing Yes □ No □
Thumb, pacifier, or finger sucking Yes □ No □ Grinding of teeth Yes □ No □

--------------------------- **FOR COMPLETION BY PATIENT/PATIENT REPRESENTATIVE** ---------------------------

_________________________________ _________________________________ _________________________ ____________
Patient/Parent/Guardian Signature Name (printed): Relationship to Patient or Patient Date

--- **FOR COMPLETION BY PROVIDER** ---

Provider Signature: ____________________________ Date: ________________________

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