



KIMBERLY D. THIEL, D.D.S.

Practice Limited to Children
CHILD'S HISTORY



Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Has your child ever had any of the following medical problems?

- | | |
|-----------------------------|---------------------------|
| Y N ADD/ADHD | Y N Heart murmur |
| Y N Allergies to any drugs | Y N Hemophilia |
| Y N Asthma | Y N Hepatitis |
| Y N Inhaler carried | Y N HIV+/Aids |
| Y N Cancer | Y N Kidney/liver problems |
| Y N Congenital heart defect | Y N Latex allergy |
| Y N Convulsions/epilepsy | Y N Rheumatic fever |
| Y N Diabetes | Y N Severe food allergies |
| Y N Handicaps/disabilities | Y N Tuberculosis (TB) |
| Y N Hearing impairment | |

Child's Physician: _____

Phone: _____ Date of last visit: _____

Reason: _____

Please list all drugs that your child is currently taking: _____

Please list any allergies: _____

Child ever been hospitalized? _____ When? _____

Why? _____

Please explain any medical problems that your child has: _____

Does your child have any limiting mental or emotional problems?

Why did you bring your child to the dentist today?

Has your child ever had a serious/difficult problem associated with previous dental work? _____

Previous/Present Dentist: _____

Date of last visit: _____

Whom may we thank for referring him/her: _____

Are there any questions you have regarding your child's dental development or care? _____

Does your child have or do any of the following?

- | | |
|---------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Clench/grind | <input type="checkbox"/> Pacifier habit |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Breast feed |
| <input type="checkbox"/> Thumb/finger habit | <input type="checkbox"/> Baby bottle/sippy cup |

Does your child receive fluoride in any of these forms?

- | | |
|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Prescribed tablets/liquid | <input type="checkbox"/> Fluoridated water |
| <input type="checkbox"/> Fluoride rinse | <input type="checkbox"/> Fluoride toothpaste |

Please list all of your children below

_____ Age ____	_____ Age ____	_____ Age ____
_____ Age ____	_____ Age ____	_____ Age ____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical state. I also understand that insurance claims are sent electronically. **CONSENT:** the signature of the parent or guardian below authorizes the completion of all agreed upon dental services and the use of those methods and techniques appropriate thereto. This consent shall remain in full force and effect until cancelled by either party on behalf of:

Child's name _____

By _____ Relationship _____

Date _____ 20____

