



Parent or guardian must accompany all minors under age 18 during their dental visits.

CHILDREN'S MEDICAL HEALTH HISTORY

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent's Name \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Referred To Us By: \_\_\_\_\_  
School: \_\_\_\_\_  
Dental Insurance Co. Name: \_\_\_\_\_  
Most Convenient Day & Time For Your Dental Appointments: \_\_\_\_\_  
Purpose of This First Dental Visit: \_\_\_\_\_

Person Financially Responsible For This Account: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Employment Name & Address: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Is it okay to contact your Emergency Contact with your present medical condition? \_\_\_\_ Yes \_\_\_\_ No

Please check the best answer, and complete the blank lines where appropriate:

- Is this the patient's 1st visit to any dentist? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Is he (she) under medical treatment now? . . . . . \_\_\_\_ Yes \_\_\_\_ No  
In the past year? If YES, for what? \_\_\_\_\_
- Does he (she) brush his teeth less than twice a day? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Does he (she) have any allergies? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Is he (she) allergic to any particular medications? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Has he (she) ever had a reaction to Novocaine/local anesthesia? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Does he (she) have frequent nose bleeds? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Is he (she) taking any medication now? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Has he (she) had a recurring sore throat? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Is he (she) considered a nervous person? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Does he (she) eat between meals? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Has he (she) ever had a sever toothache? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Has he (she) had any injuries to his (her) teeth? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Has he (she) gained or lost much weight lately? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Check if your child ever had: \_\_\_\_rheumatic fever; \_\_\_\_diabetes; \_\_\_\_epilepsy; \_\_\_\_thrush;  
\_\_\_\_anemia; \_\_\_\_kidney trouble; \_\_\_\_liver trouble; \_\_\_\_heart trouble; \_\_\_\_hepatitis; \_\_\_\_asthma;  
\_\_\_\_tuberculosis; \_\_\_\_circulatory, bleeding problems; \_\_\_\_immune system diseases?  
other illnesses . . . . . \_\_\_\_ Yes \_\_\_\_ No  
If YES, what: \_\_\_\_\_
- Does he (she) have any mouth habits? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- How long since he (she) has been to a dentist? \_\_\_\_\_
- What was done at this visit? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Did he (she) make regular visits before then? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- Did he (she) have X-rays taken regularly? . . . . . \_\_\_\_ Yes \_\_\_\_ No
- How often does he (she) brush his (her) teeth? \_\_\_\_\_ When: \_\_\_\_\_

Does he or she have a hard time sleeping or breathing at night? . . . . . \_\_\_\_ Yes \_\_\_\_ No

Does he or she have their tonsils? . . . . . \_\_\_\_ Yes \_\_\_\_ No

Does he or she snore? . . . . . \_\_\_\_ Yes \_\_\_\_ No

Click **SUBMIT** button to send your completed form to our office. **This button only works in Acrobat.**  
If you are having trouble, you can send the form in an email to: [info@chemungfamilydental.com](mailto:info@chemungfamilydental.com)