MICHAEL S. TOSATTI, DMD

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Dentistry for Adults and Children

Child Health History

Child's Name _____ Sex ___ Birth Date_____Grade in school_____

Number of children in family_____Ages_____

Father's Name_____ Mother's Name_____ _____

Father employed by_____ How long_____Business phone_____Cell phone _____

Business address _____

Mother employed by_____ How long_____Business phone_____Cell phone _____

Business address _____

Home address_____ City_____ State_____ Zip Code_____

Home phone_____Father's address (if different from above)_____

Child lives with whom_____Person financially responsible_____

For the following questions, please (x) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care. This office does not use this information to discriminate.

DENTAL HISTORY

	Yes	No
1. When was your child's last visit to the dentist? _____ For what service? _____		
2. Has your child complained about dental problems? ..... If yes, describe: _____	❑	❑
3. Any unhappy dental experiences?	❑	❑
4. Any injuries to mouth-teeth-head? ..... If yes, describe: _____	❑	❑
5. Any mouth habits – thumb sucking, nail-biting, mouth-breathing, nursing/bottle habits, pacifier, etc.?	❑	❑
6. Any unusual speech habits?	❑	❑
7. Does your child brush teeth daily?	❑	❑
8. Do you assist child with tooth brushing?	❑	❑
9. Is dental floss used?	❑	❑
10. Brand of toothpaste used? _____		
11. Is there fluoride in your drinking water?	❑	❑
12. Is fluoride taken in any other form? ..... Type: _____	❑	❑
13. Does your child take a vitamin supplement?	❑	❑
With iron?	❑	❑
14. Child's attitude toward dentistry _____		
15. Do you desire complete dental service for your child?	❑	❑
16. Orthodontic appliances worn now or ever been?	❑	❑
17. Were difficulties encountered during pregnancy or early childhood? ..... Explain: _____	❑	❑

MEDICAL HISTORY

	Yes	No
Is your child in good health?	❑	❑
Is your child currently being treated for any illness or conditions?	❑	❑

If yes, what is/are condition(s) being treated?_____

_____

Pediatrician or family physician _____

Phone _____

Has your child recently, or is he/she presently, taking any medicine(s) including non-prescription medicine?	❑	❑

If yes, what medicine(s) are they taking?

Prescribed medication(s)/dosage:_____

_____

Over the counter: _____

Other alternative medical therapies: _____

Is your child a slow healer?	❑	❑
Has your child ever bled excessively from a cut or surgery?	❑	❑

If yes, please explain: _____

	Yes	No
Has your child ever had a tooth extracted?	❑	❑
Any complications?	❑	❑

If yes, what?_____

Does your child bruise easily?	❑	❑
Has your child ever had an allergic reaction to any drugs, foods, medications or materials?	❑	❑

If yes, specify type of reaction:_____

Has your child ever been an overnight patient in a hospital?	❑	❑

When? _____

For what reason? _____

Has your child had any operations?	❑	❑

When?_____Type?_____

Has general anesthetic ever been administered to child?	❑	❑

When? _____Where?_____

Why? _____

Were there any complications? _____

Please check a response to indicate child has or has not had any of the following diseases or problems.

	Yes	No
Anemia	❑	❑
Asthma	❑	❑
Aids or HIV infection	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑
___ Artificial heart valves	❑	❑
___ Congenital heart defects	❑	❑
___ Heart murmur	❑	❑
___ High blood pressure	❑	❑
___ Low blood pressure	❑	❑
___ Mitral valve prolapse	❑	❑
___ Rheumatic heart disease/Rheumatic fever	❑	❑
Cerebral or mental condition	❑	❑

If yes, specify:_____

Chicken pox	❑	❑
Diabetes	❑	❑
Ear aches	❑	❑
Epilepsy	❑	❑
Hepatitis, jaundice or liver disease	❑	❑

	Yes	No
Kidney problems	❑	❑
Measles	❑	❑
Mumps	❑	❑
Polio	❑	❑
Respiratory problems	❑	❑
If yes, specify below	❑	❑
___ Bronchitis, etc	❑	❑
___ Pneumonia	❑	❑
___ Whooping cough	❑	❑
Strep throat	❑	❑

Does your child have any disease, condition or problem not listed above that you think I should know about?

Please explain:_____

Has your child's pediatrician or previous dentist recommended that your child take antibiotics prior to any dental treatment?	❑	❑

If yes, what antibiotics and dose?_____

NOTE: Both doctor and patient/legal guardian are encouraged to discuss any and all relevant patient health issues prior to treatment.

The above information is true to the best of my knowledge. I hereby grant Michael S. Tosatti D.M.D., 1067 Farmington Avenue, Kensington, CT 06037, to administer any treatment agreed upon or to administer such anesthetics and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

_____ _____

Signature of patient/legal guardian — Michael S. Tosatti, DMD

HEALTH INFORMATION UPDATE (DO NOT COMPLETE ON FIRST VISIT)

I have reviewed and updated my child's information sheet and recorded any changes.

Signature of patient/legal guardian _____ Date _____