



- 1220 Oak Park Dr., Fort Collins, CO 80525 ~ Phone (970) 223-8687 ~ Fax (970) 225-1574
- 383 W. Drake Rd, #103, Fort Collins, CO 80526 ~ Phone (970) 377-2500 ~ Fax (970) 207-1971
- 1122 9th St., #101, Greeley, CO 80631 ~ Phone (970) 353-5203 ~ Fax (970) 353-9441

HEALTH HISTORY

We believe that to best serve your child's dental health, we must understand your child in the larger context of his/her social and medical history. Please help us by thoughtfully answering the following questions. Please note that all health histories are held in strict confidence among our team. Complete both pages of the form.
 (ToothZone Office: (970) 223-8687(TOTS))

_____ M / F
 Child's Name (Last, First) _____ Child's Nickname _____ Date of Birth _____ Weight _____

Child's Physician _____ Phone _____ Family Dentist _____
 Physician's Address _____

Is the child under care for any medical conditions? (Y / N) Medical diagnosis? _____
 Immunizations up to date? (Y / N / Unsure) Medication taken by child? _____
 Has child ever spent the night in a hospital? Explain: _____

Allergies: Latex (Y / N) Metal (Y / N) Foods: _____
 Medications: _____
 Reaction to above allergies: _____

Has your child ever had or been diagnosed with any of the following:

- | | |
|--|--|
| <p>(Y) (N)</p> <p>____ Anemia
 ____ Blood Disease
 ____ Blood Transfusions
 ____ Bruises Easily
 ____ Hemophilia
 ____ Sickle Cell Trait or Disease</p> <p>(Y) (N)</p> <p>____ Asthma
 ____ Respiratory Problems
 Disease/RSV
 ____ Heart Surgery
 ____ Heart Murmur/Defect
 ____ High Blood Pressure
 ____ Rheumatic Fever</p> <p>(Y) (N)</p> <p>____ Arthritis
 ____ Bone/Joint Problem TMJ
 ____ Headaches
 ____ Metabolic Disorder
 ____ Muscle Disorder</p> | <p>(Y) (N)</p> <p>____ Aids/HIV
 ____ Cancer or Malignancy
 ____ Chronic Illness
 ____ Diabetes
 ____ Epilepsy
 ____ Hepatitis/Liver disease
 ____ Kidney Disease
 ____ Transplant _____</p> <p>(Y) (N)</p> <p>____ Birth Defects
 ____ Child Abuse
 ____ Concussion
 ____ Growth Problems
 ____ Premature Birth
 ____ Surgery _____
 ____ Syndrome _____</p> <p>(Y) (N)</p> <p>____ Brain Injury
 ____ Developmental Delays
 ____ Hearing and/or Speech Problems
 ____ Hyperactivity/ADD/ADHD
 ____ Neurological Disorder</p> |
|--|--|

Dentist's Notes

HEALTH HISTORY REVIEWED

- No Concerns
 - Medical Alert
 - Allergy _____
 - PreMed _____
 - Call MD _____
- Doctor's Initials _____

Are there any other conditions we need to know? _____

Has your child ever had traumatic injury to the head? _____

Has your child ever had traumatic injury to the teeth? _____



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Health History – Page 2

Please answer based upon your child’s age:

- Feeding History (ages 0 – 2.5 years):
 My child was: ___ breast fed ___ bottle fed ___ combination
 Bottle introduced at age: _____
 Bottle Use: ___ currently used ___ discontinued (At what age? _____)
- Oral Hygiene (ages 0 – 9 years):
 Have you ever received instruction on how to clean your child’s teeth? ___yes, ___no
 My child brushes ___times a day. An adult (___supervises, ___helps, ___brushes, ___none) per day.
 My child has their teeth flossed (___ every day, ___occasionally, ___not currently).
- Fluoride Use (all ages):
 When did your child begin to use toothpaste? _____ How often / day? _____
 Who applies the toothpaste to the brush? ___child, ___adult
 My child (___does, ___did, ___did not) receive supplemental fluoride drops or tablets.
 Our primary water supply (___does, ___does not, ___unsure) contain fluoride.
- Habits (all ages):
 My child (___does, ___does not) suck a (___ thumb, ___ finger, ___pacifier).
 When, where and how often? _____ Stopped at age: _____
- Dental History (all ages):
 Is there any history in your family of any:
 ___malocclusions (bad bites), ___missing teeth, ___extra teeth, ___other(explain _____)
 Do you think there is anything wrong with your child’s teeth? _____
 Has your child ever had a ___space maintainer, ___retainer, ___braces, ___ or any other orthodontic treatment?
 (Explain: _____)
 What is the primary reason for today’s visit? _____
- Family History (all ages):
 Do mother and father live together? ___yes, ___no
 Is your child adopted? ___yes, ___no If yes, when? _____
 Please explain any recent family status changes (divorce, separation, death, etc.), and note when your child experienced this change: _____
 Is your child receiving any therapy or extra help in any area? _____
- Referral (all ages):
 How did you hear about our office? (List name or media responsible for referral): _____

CONSENT

It is necessary, because your child is a minor, for permission to be obtained from a parent/legal guardian before necessary treatment is performed. The signature of the parent/guardian below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment, regardless of insurance coverage.

Also, the undersigned consents to the use of agreed upon x-rays, study models, photographs or any other diagnostic aids used for educational purposes. I fully understand this consent and have no further questions.

Signed: _____ Date: _____