HOPSCOTCH
CHILDREN'S GENERAL DENTISTRY

Health History

Child's Pediatrician _____ Phone number _____
Last Exam _____ Is your child under a physician's care? (Y) (N)
If yes, please list _____
Is your child taking any medications (including over the counter)? (Y) (N) _____
Is your child allergic to any medications? (Y) (N) If yes, please list _____
Any history of hospitalization or surgery? (Y) (N) If yes, when?_____
Is your child fully up-to-date on all immunizations? (Y) (N)
Does your child have allergic reaction to: (if yes; please check all that apply)

☐ Peanut/Tree Nuts	☐ Soy	☐ Latex/Rubber	☐ Pollen/Dust	☐ Anesthetic
☐ Eggs	☐ Metals	☐ Animals	☐ Berries	☐ Acrylic
☐ Milk	☐ Wheat	☐ Dyes/Coloring	☐ Antibiotics	☐ Other

Has your child had a history of the following?

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
Anemia	Y N	Cerebral Palsy	Y N	Herpes	Y N
Allergies	Y N	Chemo/Radiation Therapy	Y N	Immune Disorder	Y N
Arthritis/Joint	Y N	Cystic Fibrosis	Y N	Kidney	Y N
Asthma	Y N	Delayed Development	Y N	Liver	Y N
Allergies to Meds	Y N	Depression/Anxiety	Y N	Murmur	Y N
Autism	Y N	Diabetes	Y N	Muscular Disorder	Y N
Bladder	Y N	Down's Syndrome	Y N	Premature Birth	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Rheumatic Fever	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Speech Disorder	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	Sinusitis	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	TMJ Problems	Y N
Cancer/Malignancy	Y N	Hearing Impaired	Y N	Tuberculosis	Y N
Other:_____		HIV/ADS	Y N	Visual Impaired	Y N

Dental History

Is this your child's dental first visit? (Y)(N) If no, previous dentist? _____
Phone: _____ Date of last visit: _____/_____/_____
How was his/her experience? _____ X-rays taken? (Y) (N)
Child's attitude toward the dentist or dental care _____
Has your child had any injuries to teeth, mouth or head? (Y)(N) Please describe: _____
_____
Has your child done any of the following (past or present)? Please apply check:

☐ Thumb/finger sucking	☐ Pacifier	☐ Nail biting	☐ Lip sucking	☐ Mouth-breathing
☐ Teeth Grinding	☐ Snoring	☐ Nursing	☐ Bottle feeding	

Is your water fluoridated? (Y) (N) Does your child take fluoride supplements? (Y) (N)
Fluoride Toothpaste? (Y) (N) How often does your child brush his/her teeth? _____
With adult supervision? (Y) (N) Floss ? (Y) (N)
How may we help make this visit a positive experience for your child? _____

The permission of a parent or guardian is necessary for dental treatment of a minor. I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's health status. I authorize the dental staff to perform any necessary dental services my child may need. I understand that by signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage. I further understand that all payments are due on the day services are rendered.

Parent/Guardian Signature: _____ Doctor's Signature: _____

Date:_____/_____/_____ Date:_____/_____/_____