

Carolina Children's Dentistry

Dr. Felicia L. Goins • Dr. Lisbeth W. Poag • Dr. Sharlene Martin • Dr. Auchana Tocharoen • Dr. Lisa M. Cherry

SOCIAL AND HEALTH HISTORY

This record is confidential and for use only within this office

I. SOCIAL HISTORY

Child's Name _____ Date of Birth _____ male
female
Preferred Name _____ SS# _____ School _____ Grade _____
Brothers _____ Sisters _____ Hobbies & Pets _____
Home Address _____ Home Phone _____
City _____ State _____ Zip _____
Father's Name _____ SS # _____
Father's Email _____ Father's Mobile _____
Father's Employer _____ Father's Business Phone _____
Father's Driver's License # _____ Father's Date of Birth _____
Mother's Name _____ SS # _____
Mother's Email _____ Mother's Mobile _____
Mother's Employer _____ Mother's Business Phone _____
Mother's Driver's License # _____ Mother's Date of Birth _____
Person financially responsible for this account? Mother _____ Father _____ Other _____
If "other," give person's name _____
Do you have dental insurance? Yes _____ No _____ Policy # _____ Co. _____
Whom may we thank for your referral to our office? _____
Has this office rendered treatment to any other family member? _____
Please list names _____

II. MEDICAL HISTORY

Condition of the child's general health _____ Height _____ Weight _____
Child's physician _____
Address _____ Telephone _____
Has your child ever bled excessively from a cut or injury? _____
_____ Yes _____ No Does your child have physical or mental disabilities? If yes, explain _____
_____ Yes _____ No Has your child ever been hospitalized? Date _____ Reason _____
_____ Yes _____ No Has your child ever had a blood transfusion? Date _____ Reason _____
_____ Yes _____ No Has your child received emergency medical treatment within the last six months? If yes, explain _____
_____ Yes _____ No Has your child ever had hearing, sight, speech or learning problems? If yes, explain _____
_____ Yes _____ No Is your child currently receiving speech therapy? If yes, by whom _____
_____ Yes _____ No Has your child ever received injuries to the head, jaw, mouth, or teeth? If yes, describe _____
_____ Yes _____ No Is your child allergic to any medicine or food? If yes, what _____
_____ Yes _____ No Is your child taking any medicine now? If yes, what _____

How long since your child's last physical examination? _____

Indicate any of your child's past or present conditions:

- | | | | | | |
|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|-------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hyperactivity |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Auto Immune Deficiency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding tendency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver disease (Jaundice) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lung disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental Retardation |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Muscle disorders |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cough more than 3 weeks | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nose/Throat disorders |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emotional problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle-Cell Anemia |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Endocrine disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach problems |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart condition/murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Unexplained Rapid Weight Loss |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vomiting with Blood |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other: _____ |

Indicate changes in your child's Medical History (for previous patients) _____

III. DENTAL HISTORY

- Yes No Is this your child's first visit to the dentist?
- Yes No Has your child experienced any unfavorable reactions from previous dental or medical care?
If yes, explain _____
- Yes No Has your child had a toothache recently?
- Yes No Has your child received any trauma to his/her teeth?
- Yes No Does your child have any history of mouthbreathing, thumbsucking, fingersucking, lip/nail biting or other habits? (If yes, underline)
- Yes No At what age did your child stop using a nursing bottle? _____
- Yes No Is your child taking any vitamins or fluorides?
- Yes No Does your family drink well or city water?
- Yes No Does your child have a dental condition about which you are especially concerned?
If yes, explain _____
- Yes No Is there anything else about your child that you think I should know in order to better plan his/her dental treatment? _____

IV. CONSENT

I acknowledge that the above information is correct and authorize Dr. Felicia Goins or Dr. Lisbeth Poag and staff to provide dental and related medical/surgical treatment as deemed necessary utilizing proper and acceptable methods to complete same, including diagnostic radiographs and photographs. I also understand that payment is expected as services are rendered.

Method of Payment: Check Cash Credit Card.

Parent or Legal Guardian _____ Date _____