# Carolina Children's Dentistry

Dr. Felicia L. Goins • Dr. Lisbeth W. Poag • Dr. B. Brian Han

## 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:

| | | | | | |
|---|---|---|---|---|---|
| ____ Yes | ___ No | Anemia | ____ Yes | ___ No | Hyperactivity |
| ____ Yes | ___ No | Asthma | ____ Yes | ___ No | Kidney disease |
| ____ Yes | ___ No | Autistic | ____ Yes | ___ No | Liver disease (Jaundice) |
| ____ Yes | ___ No | Auto Immune Deficiency | ____ Yes | ___ No | Lung disease |
| ____ Yes | ___ No | Bleeding tendency | ____ Yes | ___ No | Sleep Apnea |
| ____ Yes | ___ No | Blood disease | ____ Yes | ___ No | Special needs |
| ____ Yes | ___ No | Bone disorders | ____ Yes | ___ No | Muscle disorders |
| ____ Yes | ___ No | Convulsions | ____ Yes | ___ No | Nose/Throat disorders |
| ____ Yes | ___ No | Cough more than 3 weeks | ____ Yes | ___ No | Rheumatic Fever |
| ____ Yes | ___ No | Diabetes | ____ Yes | ___ No | Skin disease |
| ____ Yes | ___ No | Ear disorders | ____ Yes | ___ No | Sickle-Cell Anemia/Trait |
| ____ Yes | ___ No | Emotional problems | ____ Yes | ___ No | Stomach problems |
| ____ Yes | ___ No | Endocrine disorders | ____ Yes | ___ No | Tuberculosis |
| ____ Yes | ___ No | Epilepsy | ____ Yes | ___ No | Tumors |
| ____ Yes | ___ No | Eye disorders | ____ Yes | ___ No | Unexplained Rapid Weight Loss |
| ____ Yes | ___ No | Heart condition/murmur | ____ Yes | ___ No | Vomiting with Blood |
| ____ Yes | ___ No | Hemophilia | ____ Yes | ___ No | Other: |
| ____ Yes | ___ No | Hepatitis | | | |
| ____ Yes | ___ No | High Blood Pressure | | | |

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, Dr. Lisbeth Poag or Dr. B. Brian Han 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 _____