LSUHealthNewOrleans School of Dentistry

Pediatric Dentistry Health History and Patient Information

Axium #______________

Patient's Name____ Nickname____________________ Date________________
(Last) (First)

Age___________ Date of Birth_____________________ Sex______________ Race_____________ Grade_________________

Parent/Guardian____ Relationship to child___________________________

Telephone____
(Home) (Cell) (Work) (Please circle the best number to contact you.)

Address____
(Number and Street) (City) (State) (Zip)

Brothers______________________________ Sisters_____________________________ Pets______________________________

Name of child's physician____________________________ Telephone_____________________ Date last seen_____________

Pharmacy____ Telephone _______________________________

Emergency Contact____ Telephone__________________________________

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

1. Person responsible for child's financial support____

   Address____ Telephone_____________________

2. Method of payment for dental treatment (Please check below)

   ☐ CHAP ☐ Children's Hospital Employee Dependent ☐ LSUSD Employee Dependent ☐ Medicaid ☐ Self-pay

Reason for bringing child to the dentist____

____

HISTORY

	YES	NO
1. Is your child being treated by a physician at this time? If yes, why___________________	☐	☐
2. Has your child ever been a patient in a hospital? If yes, why?___________________	☐	☐
3. Has your child ever received general anesthesia or sedation? If yes, when?___________________	☐	☐
4. Is your child allergic to anything? (medicine, food) If yes, what?___________________	☐	☐
5. Is your child taking any medicines at this time? If yes, what?___________________	☐	☐
6. Were there any problems at birth/premature delivery? If yes, what?___________________	☐	☐
7. Are immunizations up to date?	☐	☐

8. Do you consider your child to be
   - ☐ advanced in the learning process
   - ☐ progressing normally
   - ☐ slow in the learning process

9. How do you think your child will cooperate for this appointment?
   - ☐ Well behaved
   - ☐ Unsure
   - ☐ Uncooperative

10. Does your child attend any clinic(s)? (Check all that apply)

☐ Amputee	☐ Opthalmology
☐ Audiology	☐ Orthopaedic
☐ Cleft Palate	☐ Otolaryngology
☐ Craniofacial	☐ Plastic Surgery
☐ Heart	☐ Pulmonology
☐ Hematology	☐ Rheumatology
☐ Nephrology	☐ Scoliosis
☐ Neurosurgery	☐ Spine
☐ Oncology	☐ Urology
☐ Developmental Delay	
☐ Other__________________________	

Is this a CSHS Patient ☐ Yes ☐ No

ORGANS AND SYSTEMS

Has this child ever had any treatment for any of the following? Please check below

YES	NO		YES	NO	
☐	☐	Behavior Disorders	☐	☐	Kidney-Bladder
☐	☐	Blood-Circulatory	☐	☐	Liver
☐	☐	Bones	☐	☐	Muscles
☐	☐	Endocrine Glands	☐	☐	Nervous System
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Respiratory- Lungs
☐	☐	Gastrointestinal-stomach	☐	☐	Skin
☐	☐	Heart	☐	☐	Tonsils/Adenoids

☐ **This child has NOT had any treatment for the above organs and systems.**

ILLNESS

Has this child ever been diagnosed as having any of the following conditions? Please check yes or no.

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Excessive Bleeding Problems	☐	☐	Pneumonia
☐	☐	Allergy	☐	☐	Eye Problems	☐	☐	Pregnant
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Psychiatric Disorder
☐	☐	Asthma	☐	☐	Gastric Disease/Reflux	☐	☐	Rheumatic Fever
☐	☐	Autism	☐	☐	Hearing Loss	☐	☐	Scarlet Fever
☐	☐	Brain injury	☐	☐	Heart Disease	☐	☐	Scoliosis
☐	☐	Bronchitis	☐	☐	Hepatitis – Type__________	☐	☐	Sickle Cell Disease/Trait
☐	☐	Cancer	☐	☐	High/Low Blood Pressure	☐	☐	Sinus Problems
☐	☐	Cerebral Palsy	☐	☐	HIV/AIDS	☐	☐	Sore throats-frequent
☐	☐	Chicken Pox	☐	☐	Hyperactivity/ADD/ADHD	☐	☐	Snoring/Sleep Apnea
☐	☐	Cleft lip/palate	☐	☐	Jaundice	☐	☐	Spina Bifida
☐	☐	Congenital Birth defects	☐	☐	Leukemia	☐	☐	Syndrome_________
☐	☐	Convulsions/seizures	☐	☐	Measles	☐	☐	Tetanus
☐	☐	Cystic Fibrosis	☐	☐	Mumps	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Mouth Breathing	☐	☐	Venereal Disease/STD
☐	☐	Drug or alcohol abuse	☐	☐	Nutritional Deficiency	☐	☐	Whooping Cough
☐	☐	Eczema	☐	☐	Orthopaedic Problems	☐	☐	Other______________
☐	☐	Epilepsy	☐	☐	Intellectual/Developmental Disability			____________________

☐**This child has never been diagnosed as having any of the above conditions**

DENTAL HISTORY

	YES	NO
1. Has your child ever been seen by a dentist before? Date last seen_________Name of dentist___________	☐	☐
2. Has your child ever had dental radiographs (x-rays) made? If yes, when?____________________________________	☐	☐
3. Has your child received fluoride in any form? If yes, what?_____________________________________	☐	☐
4. How many times a day does your child brush their teeth?_________________		
5. Do you brush your child's teeth?	☐	☐
6. At what age did your child stop bottle/breast feeding?____________________		
7. Does your child have snacks in between meals?	☐	☐
8. Have there been any injuries to any teeth? If yes, explain____	☐	☐
9. Has your child had any problem with dental treatment in the past? If yes, explain:____	☐	☐
10. Does your child smoke or use tobacco products?	☐	☐

Office Use Only

Summarize History________________
____
____
____
____
____
____

B.P._______

Height________ %______________

Weight________ %_____________

_______________________ _______
Reviewer Date

11. Does your child have any of the following habits? (**Check all that apply**) ☐ Lip Sucking/Biting ☐ Nail Biting ☐ Clenching/Grinding ☐ Prolonged Bottle/Pacifier ☐ Thumb/Finger Sucking ☐ Mouth Breather ☐ Tongue Thrusting

Is there anything else that you think we should know about your child____

____

I certify that I have read and understand the above questions. I will not hold LSUHSC Dentists or any member of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

_______________________________ _______________________________ ______________
Signature of person completing form Relationship to patient Date