PEDIATRIC HEALTH HISTORY FORM

WELCOME TO DOC BROCHS

WE ARE VERY HAPPY THAT YOU'RE HERE TO SEE US!!!

Please take a few minutes to fill out this form as completely as possible. If you have any questions we'll be glad to help you. We look forward to working with you and your child!

PATIENT INFORMATION

DATE_____

Last name_____ First name_____ Initial/Nickname_____

Home address_____

City_____ State_____ Zip code_____

Date of Birth_____ School_____ Current grade_____

Parent(s) name(s) or legal guardian_____ Social Security#_____

Home address (if different than child's)_____

Home telephone_____ Business or cellular telephone_____

Person responsible for account (if other than parent)_____

Name of person providing insurance_____

Social Security#_____ Date of birth_____

Employer_____ Subscriber/Insurance group #_____

Insurance company_____ Telephone _____

DENTAL HISTORY

Date of last dental visit_____ Any unhappy experiences?_____
Has child complained of dental problems/pain?_____
_____
Does child brush daily?_____ How often?_____
Any injuries to mouth/teeth/head?_____
_____
Any mouth habits? i.e.: Thumb-sucking, nail biting, bottle habits, pacifier, etc.:
_____
Any unusual speech habits?_____
Any lost teeth?_____How many?_____
Orthodontic appliance(s), now or ever?_____

MEDICAL HISTORY

Child's primary physician_____Telephone_____
Date of last check-up_____Have there ever been any serious illnesses/operations?
If yes, please explain_____
Is child under the care of a physician at this time (other than well check-ups)?_____
If yes, please explain_____
Is your child currently taking any prescription medication(s)?_____
If yes, please list_____

Please check if your child has had any of the following:

__AIDS/HIV/ARC __ANEMIA __ASTHMA __ARTHRITIS
__DRUG ALLERGIES, PLEASE LIST_____
__FOOD ALLERGIES, PLEASE LIST_____
__MATERIAL ALLERGIES (latex, wool, chemicals, metals)_____
__BLOOD DISORDERS __CANCER __CHICKEN POX __COUGH UP BLOOD
__ COUGH (PERSISTENT) __CONGENITAL HEART LESIONS __DIABETIC
__FAINTING __ HEADACHES __HEART MURMUR __ HEMOPHILIA __ JAUNDICE
__KIDNEY DISEASE __LIVER DISEASE __HEPATITIS __RESPIRATORY DISEASE
__RHEUMATIC FEVER __SINUS PROBLEMS __SKIN RASH __EPILEPSY
__ STROKE __TUBERCULOSIS __ SEASONAL ALLERGIES (pollens, etc.)_____
__OTHER_____

INFORMED CONSENT

THE INFORMATION ON THIS QUESTIONNAIRE IS ACCURATE TO THE BEST OF MY KNOWLEDGE.I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY DR BROCHSTEIN TO HELP DETERMINE AND PROVIDE THE MOST APPROPRIATE, HEALTHFUL DENTAL TREATMENT FOR MY CHILD.I GIVE, DR. ROBERT E. BROCHSTEIN, AND HIS CLINICAL TEAM PERMISSION TO PROVIDE DENTAL TREATMENT TO MY MINOR CHILD.TREATMENT MAY INCLUDE NECESSARY X-RAYS, PHOTOS, OR STUDY MODELS TO ENABLE A COMPLETE DIAGNOSIS AND TREATMENT.

SIGNED_____DATE_____
Parent or legal guardian