Form 2-2007

Smiles Dentistry for Kids, LLC
Matthew Hillman DDS

Child's Information and Health History

Tell Us About Your Child

Name (last, first): ________________________________ Preferred Name: __________________ Sex: M F DOB (mm/dd/yyyy): __________

Address: *(if you are bringing more than one child, only complete the address section once)*

Street: ____ City: ______________________________ State: _____ Zip code: _________________

Phone: _____________________________ School: ____________________________ Grade: ____________

Hobbies or Special Interests:

Is your child currently under the care of a physician?	Yes	No	Name: _______________________ Phone: __________________
Has your child ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: ____________________________________
Has your child ever experienced severe head or neck injuries?	Yes	No	If yes, please explain: ____________________________________
Is your child on a Dr. prescribed diet?	Yes	No	If yes, please explain: ____________________________________
Is your child taking any medications?	Yes	No	If yes, please list all medications and the reason for taking:
Has your child ever used illicit drugs or used tobacco?	Yes	No	If yes, please explain:
If your child has reached menses, is she or could she be pregnant?	Yes	No	is she currently taking birth control? Yes No

Does your child have allergies to any of the following?

Penicillin Aspirin Acrylic Metals Latex Codeine Local Anesthetics

Other Allergies:

Does your child have, or ever had any of the following?

ADD/ADHD	Y	N	Chemotherapy	Y	N	Hay Fever	Y	N	Parathyroid Disease	Y	N
AIDS/HIV	Y	N	Chicken Pox	Y	N	Heart Failure	Y	N	Radiation Therapy	Y	N
Anaphylaxis	Y	N	Cold Sores/ Fever Blisters	Y	N	Hepatitis A	Y	N	Renal Dialysis	Y	N
Anemia	Y	N	Congenital Heart Defects	Y	N	Hepatitis B or C	Y	N	Rheumatic Fever	Y	N
Arthritis/Gout	Y	N	Corstisone/Steriod Treatment	Y	N	Herpes	Y	N	Scarlet Fever	Y	N
Artificial Heart Valve	Y	N	Developmental Delay	Y	N	High Blood Pressure	Y	N	Sickle Cell Disease/Trait	Y	N
Artificial Joint	Y	N	Diabetes	Y	N	Hives/Rash	Y	N	Seizures/Epilepsy	Y	N
Asthma	Y	N	Drug Addiction	Y	N	Hypoglycemia	Y	N	Sinus Problems	Y	N
Bleeding Disorder	Y	N	Excessive Bleeding	Y	N	Irregular Heart Beat	Y	N	Snoring	Y	N
Blood Disease	Y	N	Excessive Thirst	Y	N	Jaundice	Y	N	Tuberculosis	Y	N
Blood Transfusion	Y	N	Fainting Spells/Dizziness	Y	N	Kidney Problems	Y	N	Thyroid Disease	Y	N
Breathing Problems	Y	N	Frequent Cough	Y	N	Leukemia	Y	N	Stomach Ulcers	Y	N
Bruise Easily	Y	N	Frequent Ear Infections	Y	N	Liver Disease	Y	N	STD	Y	N
Cancer	Y	N	Frequent Headache	Y	N	Neurological Disorder	Y	N			

Other medical condition(s) not listed above:
If you answered "yes" to any of the above, please elaborate:

DENTAL HISTORY

What is your primary reason for bringing your child in today?

Is your child having any dental discomfort? Yes No If yes, please explain:

When was your child's last dental visit? ______________________________________
Please rate your child's behavior at his/her last visit *(1 = poor; 10 = excellent)*: ________
Comments: