ATLANTIC DENTAL WELLNESS: HOLISTIC, RESTORATIVE, & SPORTS DENTISTRY

Leonard T. Fazio, D.D.S., Director

P: 631.474.7477 E: info@HolisticSmiles.com W: www.HolisticSmiles.com

1303 Main Street, Suite 2 | Port Jefferson, NY 11777

CHILD HEALTH HISTORY UPDATE

Patients Name_____ Date_____

Mailing Address_____ City_____ State_____ Zip_____

Sex: M F Age_____ Birth Date_____ SS#_____-_____-_____

Home Phone_____ Cell Phone_____

HEALTH INFORMATION

Has your child ever had any of the following? Please check all that apply.

- ○ AIDS
- ○ ADD/ADHD
- ○ Anemia
- ○ Artificial Joints
- ○ Asthma
- ○ Blood Disease
- ○ Cancer
- ○ Cerebral Palsy
- ○ Cleft Lip/Palate
- ○ Diabetes
- ○ Epilepsy
- ○ Excessive Bleeding
- ○ Fainting/Dizziness
- ○ Glaucoma
- ○ Head Injuries
- ○ Heart Disease
- ○ Heart Murmur
- ○ Hepatitis
- ○ Jaundice
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mental Disorders
- ○ Nervous Disorders
- ○ Reparatory Problems
- ○ Rheumatic Fever
- ○ Stomach Problems
- ○ Tuberculosis
- ○ Tumors
- ○ Ulcers
- ○ Other:

Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

_____

_____

Is your child receiving any medications or drugs? Yes No

If yes, what? _____

ALLERGIES

Is your child allergic to any of the following?

- ○ Local Anesthetics(Novocain)
- ○ Aspirin or codeine
- ○ Penicillin/other antibiotics
- ○ Foods
- ○ Latex
- ○ Other (including over the counter) _____

DENTAL HEALTH

Any injuries to mouth, teeth or head? Yes No

If yes, please explain _____

Does your child have any mouth habits? Please select all that apply.

- ○ Thumb sucking
- ○ Mouth breathing
- ○ Pacifier
- ○ Finger sucking
- ○ Nursing bottle habits

Does your child have any unusual speech habits? _____

Any orthodontic appliances worn now or ever? If yes, please explain _____

Does your child brush daily? Yes No

Do you assist child with tooth brushing? Yes No

To the best of my knowledge, all of the above answers and information provided are true and correct. If there are ever any change in my child's health, I will inform the staff at the next appointment.

Signature of parent of guardian: _____ **Date:** _____

Signature of doctor: _____ **Date:** _____