# *Pedodontic Health Questionnaire*

Name_____

Address _____ Date_____

_____ Telephone _____

Date of Birth_____ Sex _____

Name of Parent or Guardian _____

1. DO YOU HAVE A HISTORY OF

| | | |
|---|---|---|
| Y N HEART CONDITION | Y N ASTHMA | Y N CONVULSIONS |
| Y N HEART SURGERY | Y N THYROID DISEASE | Y N DIABETES |
| Y N RHEUMATIC FEVER | Y N HIVES, SKIN RASHES | Y N ANEMIA |

| Check Yes or No. (If "Yes" explain) | YES | NO |
|---|---|---|
| 2 Has child ever been seriously ill or in a hospital?<br>For what condition?_____<br>Physician's name_____<br>Address_____ | | |
| 3. Is child taking any medicine or undergoing any medical treatment at present time?<br>Nature of medicine or treatment_____ | | |
| 4. Does child have any allergies?<br>Nature of allergy_____ | | |
| 5. Has child had abnormal bleeding following cuts or dental extractions? | | |
| 6. Has child had fluoride treatments of any kind? If yes, please describe. | | |
| 7. Does child have any of the following mouth habits: thumb sucking, lip biting, mouth breathing, finger sucking, other. If yes, please describe. | | |
| 8. Has child ever experienced any complications or illness following dental treatment? | | |
| 9. Do you consider child<br>a. advanced in the learning process_____<br>b. progressing normally in the learning process_____<br>c. a slow learner_____ | | |

THE UNDERSIGNED CONSENTS TO NECESSARY RADIOGRAPHIC SURVEYS, ANESTHESIA, DIAGNOSIS, AND DENTAL TREATMENT. THE UNDERSIGNED MAY ELECT NOT TO UNDERGO CERTAIN SPECIFIC PROCEDURES.
MY SIGNATURE IS CONSENT FOR COLFAX DENTAL SERVICES TO SUBMIT CHARGES TO MY INSURANCE COMPANY, AND IT SERVES AS SIGNATURE ON FILE IN LIEU OF AN INSURANCE FORM.

SIGNATURE OF PARENT/GUARDIAN _____ DATE