LONDON DENTAL CARE Child Health/Dental History Form



American Dental Association

Paper this same December Dece						www.ada.org	
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1. Active Tuberculoss 2. Persistent Cough greater than a three-week duration. 3. Gough that produces bood? If you answer yes to any of the three items above, please step and return this form to the receptionist. Has the child had any history of, or conditions related to, any of the following: Anomia Cancer Epilepsy HiV I/AIDS Monorucledes Arbritis Centered Poley Faining Immunizations Mumps Tobacco/Drug Use Arbritis Centered Poley Faining Immunizations Mumps Tobacco/Drug Use Arbritis Centered Poley Faining Immunizations Mumps Tobacco/Drug Use Benefing discribers Cancer Heart Insert Insert Insert Insert Benefing discribers Cancer Heart Insert Inse	Home		Work				
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Name of Physician	Please list the name and phone number of the child's physician:						
Child's History 1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? 1. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: 2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: 3. Is the child allergic to anything else, such as certain foods? If yes, please explain: 3. Is the child allergic to anything else, such as certain foods? If yes, please explain: 4. How would you describe the child's eating habits? 5. Has the child ever had a serious illness? If yes, when: 5. Has the child ever had a serious illness? If yes, when: 7. Does the child have a history of any other illnesses? If yes, please ilst: 7. Does the child have any speech difficulties? 9. Does the child have any speech difficulties? 10. Does the child have any speech difficulties? 11. Has the child ever readeved a general ansettlet? 9. Does the child as any speech difficulties? 11. Has the child ever readeved a general ansettleties? 12. Is the child physically, mentally, or emotionally impaired? 13. Does the child expressed beleating when cut? 14. Is the child currently being treated for any illnesses? 14. Is the child currently being treated for any illnesses? 15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: 15. Is this the child shad any problem with dental treatment in the past? 16. Is Has the child ever suffered any injuries to the mouth, head or teeth? 17. Has the child had any problem with dental treatment in the past? 18. Has the child late drap or other with the mouth, head or teeth? 19. Has the child late drap or other with the mouth, head or teeth? 19. Has the child late drap or other with the mouth, head or teeth? 19. Has the child late only or other injuries to the mouth, head or teeth? 20. Dess the child late of the child's top bottle redding? 21. What type							
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