BRUCE C. TOILLION, D.D.S.
CHARLES E. TOILLION, D.D.S.
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DAVID B. TOILLION, D.D.S.
CHRISTOPHER W. HERZOG, D.D.S.

CHILD'S HISTORY *(These questions are of great value in aiding us to a better understanding of your child)*

Child's Full Name _____ Nickname: _____ F _____ M ____ Age _____

School: _____ Birthdate: _____ Birthplace: _____

Name of child's physician: _____ City: _____ Phone: _____

Date of last physical examination: _____ Findings: _____

Is your child presently under the care of a physician? ❒ Yes ❒ No If so, for what condition? _____

Number of children in family _____ Former Dentist _____

Is your child: In good health..... ❒ Yes ❒ No

Has your child ever been diagnosed as having HIV or AIDS Virus ..... ❒ Yes ❒ No

Has your child ever had a blood transfusion or blood products..... ❒ Yes ❒ No

Has your child ever tested positive or been exposed to Tuberculosis..... ❒ Yes ❒ No

Has your child ever had any surgeries? Explain _____ ..... ❒ Yes ❒ No

To your knowledge sensitive or allergic to any medications (name _____) ..... ❒ Yes ❒ No

Taking any medications (name _____) ..... ❒ Yes ❒ No

Has your child had any history of: (Please circle) Asthma, Rheumatic Fever, Heart Trouble, Diabetes, Fainting or Dizziness, Convulsions, Epilepsy, Excessive Bleeding, Hearing Difficulty, Speech Impediment, Mental or Emotional Disturbance, Cerebral or Spastic Condition, Liver or Kidney Disease?..... ❒ Yes ❒ No

Does your child have a special problem? ..... ❒ Yes ❒ No

If yes, please explain: _____

Has your child had any history of thumbsucking, lip sucking, lip biting (If yes, underline condition)..... ❒ Yes ❒ No

Is there any history of missing teeth in the family..... ❒ Yes ❒ No

Is your child taking fluoride pills or drops..... ❒ Yes ❒ No

Is your child in any contact sports ..... ❒ Yes ❒ No

Has your child ever had an orthodontic evaluation or treatment? ..... ❒ Yes ❒ No

Name of Doctor _____

Any unhappy dental or medical experiences..... ❒ Yes ❒ No

Child's attitude toward dentistry: _____

Purpose of call: Examination _____ Emergency _____

Is there a specific problem now?..... ❒ Yes ❒ No

Is there other information which will assist us in providing the best possible care for your child ..... ❒ Yes ❒ No

If yes, please state: _____

Who may we thank for referring you to our office? _____ Address _____

Signature _____ Date _____

HEALTH HISTORY REVIEWED & UPDATED BY PARENT OR GUARDIAN

DATE	INITIALS	DATE	INITIALS	DATE	INITIALS	DATE	INITIALS	DATE	INITIALS	DATE	INITIALS