BRUCE C. TOILLION, D.D.S.
CHARLES E. TOILLION, D.D.S.
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CHRISTOPHER W. HERZOG, D.D.S.
JARED K. KARSTETTER, 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 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

Has your child ever been diagnosed as having HIV or AIDS Virus............ ❒ 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