North Hills
8620 Duncan Ave.
Pittsburgh, PA 15237
412-367-2250

Monroeville
2790 Mosside Blvd.
Suite 140
Monroeville, PA

Beaver
244 College Ave.
Beaver, PA 15009
724-888-2684

Cranberry
20440 Rt 19
Cranberry Twp, PA
16066

PATIENT HEALTH HISTORY FORM

Today's Date _____ Email Address _____

Child's Name _____ Gender _____ Nickname _____ Weight _____

Date of Birth _____

Referred by _____

Father's Name _____

Mother's Name _____

Home address _____

Mother's Place of Employment _____

Responsibility for Account _____
Date of Birth _____
Dental Insurance Company/Self-Pay_____
Employer _____
SSN #_____

Mother's Occupation _____ Phone _____

Father's Place of Employment _____ Father's Occupation _____ Phone _____

Name of Person completing form _____ Relationship to Child _____

In case of Emergency please notify _____ Phone _____

Child's Physician _____ Phone _____ Cell _____

MEDICAL AND DENTAL HISTORY

1. Is your child having any dental problems? _____ Please explain _____
2. Is this your child's first visit to any dentist? _____ If not, date of last visit _____
3. Names & ages of brothers and sisters _____
4. Place of birth _____ Was water fluoridated? _____ Is it now? _____
5. Any problems or medications during pregnancy? _____
6. Is your child in good health now? _____ Taking any medication? _____
7. Has your child had any of the following:

Heart disease or defects _____
Diabetes _____
Convulsions _____
Kidney Disease _____
Dizziness or Fainting _____
Rheumatic Fever _____
Breathing Difficulties _____
Blood Transfusions _____

Anemia or Blood Disorders _____
Hepatitis or Liver Disease _____
Bleeding Difficulties _____
Birth Defects _____
Hearing Problems _____
Nervous Condition _____
Emotional Problems _____
Other Conditions _____

Frequent Headaches _____
Cleft Palate or Lip _____
Cerebral Palsy _____
Sight Problems _____
Any other illness _____
Delay in Physical or
Mental Development _____

8. Is your child allergic to any food or drugs? (Penicillin, Novocaine, other local anesthetics, aspirin, etc.)_____
9. Has your child ever been warned by a physician against taking any specific drug medication? _____
10. Has your child ever been hospitalized for any reason? _____ When? _____
For what reason? _____
11. Age at which first tooth erupted _____ Did your child ever sleep with a bottle? _____
What did the bottle contain? _____At what age did he/she stop? _____
Does your child brush his/her own teeth? _____ If not, who does it? _____
Does your child have any speech difficulties? _____
What habits does your child have which might affect the teeth or mouth?
Mouth breather _____ Grinding _____ Clenching _____ Sucks Thumb _____ Sucks Finger _____ Other _____
Has your child had any dental injuries? Explain _____
Has your child ever had fluoride medication at home? _____ Type _____
Diet Summary (frequent and types of sweets) _____
Has your child had any fluoride treatments? _____ Date of last treatment _____

General Dental history of other family members_____

Any other information you feel we should know about your child _____