



Dentistry For Children
Jordan E. Higham DDS

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PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: _____ Nickname: _____ Date of Birth ___/___/___
Street Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Age: _____ Sex: Male Female
School Currently Attending: _____ Grade Level: _____

PARENT INFORMATION

Parent/Legal Guardian: _____ Relation to patient: _____
Employer: _____ Work #: _____ Mobile #: _____ Date of Birth ___/___/___
Parent/Legal Guardian: _____ Relation to patient: _____
Employer: _____ Work #: _____ Mobile #: _____ Date of Birth ___/___/___
Guardian's Email: _____
Who has legal custody? _____ Dental Insurance Yes No
Person responsible for payment of account _____ SSN#: _____

WHOM MAY WE THANK FOR REFERRING YOU?

Our Website Dental Office Pediatrician Newspaper Postcard/Mailing
 Friend Yellow Pages Other - Please Specify: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Mobile: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone#: _____
Mailing Address: _____ City: _____ State: ___ Zip: _____

DENTAL HISTORY

What is the reason for your child's dental visit? _____
 Yes No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____
Name of previous dentist: _____ Phone: _____
 Yes No Has your child had any previous unpleasant experiences with dental care?
Explain _____
 Yes No Does your child suck a finger, thumb, or pacifier?
 Yes No Does your child have pain with chewing, yawning, or wide opening?
 Yes No Does your child go to bed with a bottle or sippy cup?
 Yes No Does your child snack frequently? What are their favorite snack foods? _____
 Yes No Has your child had local anesthetic? Were there any problems? _____
 Yes No Has your child been sedated for dental treatment? Were there any problems? _____
 Yes No Have your child's teeth ever been injured? Which teeth: _____
Dental treatment for trauma: _____

Please check if your child is having problems with any of the following:

Cavities Toothache Sensitive Teeth Mouth Breathing Trauma Gum Infections
 Color of Teeth Orthodontics Jaw Sounds Grinding of Teeth Other

Comments: _____

FLUORIDE HISTORY

- Yes No Is your home water supply fluoridated?
 Yes No Does your child use a fluoride toothpaste?
 Yes No Do you give your child any other forms of fluoride? What? _____

MEDICAL HISTORY

- Yes No Is your child in good health? Date of last physical exam _____
 Yes No Has your child ever had a health problem? _____
 Yes No Is your child allergic to anything? _____
 Yes No Is your child currently taking any medications? Please give medication, dose, and reason: _____
 Yes No Are your child's immunizations current?
 Yes No Have you ever been told that your child needs to take antibiotics before dental treatment?
 Yes No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: _____
 Yes No Were there any difficulties at birth? _____

- Do you consider your child to be:** advanced in the learning process
 progressing normally
 slow in the learning process

Please check if your child has been treated for any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Adverse drug reactions |
| <input type="checkbox"/> Bleeding/transfusions | <input type="checkbox"/> Mental delays | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Asthma/breathing | <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Significant injuries |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Endocrine/growth |
| <input type="checkbox"/> Tonsil/adenoid problems | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Physical delays | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Liver/GI disease | <input type="checkbox"/> Eyesight | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Sickle cell disease/trait | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Personality/social | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Abuse |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Emotional disorders |

Other: _____
If any boxes checked, please describe further: _____

CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Dr. Jordan Higham and his staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Higham to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Higham will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Just 4 kiDDS Dentistry of any changes in my child's medical status.

Legal Guardian's Signature: _____ **Date:** _____