

Pediatric Dentistry Health Information

CIGNA Dental Health



CIGNA

DATE _____

CHILD'S NAME	NICKNAME		AGE	BIRTHDATE
SCHOOL	GRADE	RESIDENCE ADDRESS	ZIP	
FATHER'S NAME	MOTHER'S NAME		PARENT'S TELEPHONE NUMBER (H) _____ (W) _____	
BROTHERS		SISTERS		
IF APPLICABLE, DENTAL INSURANCE CARRIER				
CHILD'S FAVORITE HOBBY	CHILD'S FAVORITE SPORT		ANY PETS?	

DENTAL HISTORY

YES NO

YES NO

DATE OF LAST DENTAL VISIT _____

DOES YOUR CHILD BRUSH DAILY? _____

FOR WHAT _____

DO YOU ASSIST YOUR CHILD WITH BRUSHING? _____

BY DR. _____

HOW OFTEN _____

ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS?

IS DENTAL FLOSS USED? _____

HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS? _____

ARE DISCLOSING TABLETS USED? _____

ANY INJURIES TO MOUTH, TEETH, HEAD? _____

HOW DOES YOUR CHILD RECEIVE FLUORIDE?

WATER SUPPLY TOOTHPASTE

ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING,
MOUTH BREATHING, ETC.? _____

DENTIST VITAMIN TABLETS

ANY LOST TEETH? _____

NONE OTHER _____

CHILD'S ATTITUDE TO DENTISTRY _____

MEDICAL HISTORY

CHILD'S PHYSICIAN _____ ADDRESS _____ PHONE _____

YES NO

DATE OF LAST COMPLETE PHYSICAL EXAMINATION? _____ RESULTS _____

IS YOUR CHILD IN GOOD HEALTH? _____

IS YOUR CHILD PRESENTLY UNDER CARE BY A PHYSICIAN? _____

IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS? _____

WHAT IS YOUR CHILD'S WEIGHT _____ HEIGHT _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? _____

HAS YOUR CHILD EVER HAD SURGERY? _____

EATING HABITS PRESENTLY - BRIEFLY EXPLAIN _____
ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION?

YES NO

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

YES NO

1. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE _____

2. CONGENITAL HEART DISEASE OR HEART MURMUR _____

3. ALLERGIES: A) FOOD, DUST, ETC. _____

B) DRUG, i.e. Penicillin, etc. _____

C) UNKNOWN _____

4. ASTHMA OR HAY FEVER _____

5. ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS) _____

6. DIABETES OR BLOOD SUGAR PROBLEMS _____

7. ANY PROLONGED BLEEDING OR BRUISES EASILY _____

8. KIDNEY OR BLADDER PROBLEMS _____

IF YES, PLEASE EXPLAIN _____

SUMMARY: (FOR DOCTOR'S USE)

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES
OR INFORMATION DENTIST SHOULD BE AWARE OF THAT HAS NOT BEEN COVERED ABOVE.

HISTORY TAKEN FROM

PARENT HISTORIES BY: _____ RELATIONSHIP _____ RECORDED BY _____ DATE _____

RELATIONSHIP _____ RECORDED BY _____ DATE _____

RELATIONSHIP _____ RECORDED BY _____ DATE _____

RELATIONSHIP _____ RECORDED BY _____ DATE _____

NATIVE RELATIONSHIP _____ RECORDED BY _____ DATE _____

I hereby certify the foregoing information is correct and true. Because _____ is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Authorization is hereby granted as such.

Furthermore, I will be responsible for any professional fees incurred for dental services to my child.

I authorize CIGNA Dental Health or any participating dental office to release my child's dental records to any CIGNA company for plan administrative purposes.

Signed _____ Date _____