ARRICK AND ASSOCIATES
601 Tucker Street
Raleigh, NC 27603
(919) 833-8100

CHILD HEALTH QUESTIONAIRE

Name of CHILD_________________________ Date of Birth _________________

Address________________________ City ___________________Zip___________

Child's SSN__________________ Sex ___ Race ____ Weight ____Height________

Name of Mother ________________ Home Phone __________ Work ___________

Address ________________________ City _______________ Zip _____________

Mother's SSN ________________Employer/Occupation _____________________

Name of Father _______________ Home phone ____________ Work __________

Address ________________________ City ______________ Zip _____________

Father's SSN ______________ Employer/Occupation _________________________
NAME OF SCHOOL CHILD ATTENDS: ______________________________________
METHOD OF PAYMENT: Cash __ VISA/MC/ATM__ Discover__Insurance ___

****INSURANCE DEDUCTIBLE MUST BE MET AND ANY PART OF THE FEE NOT COVERED BY YOUR INSURANCE MUST BE PAID ON THE DAY THAT SERVICES ARE RENDERED.****

How were you referred to our office? Yellow Pages__Friend__List Name____________

Directions: The following questions pertain to your child's medical health, which helps us to determine how to provide the best possible care. This is confidential and should be answered honestly.

1. Have you ever been seriously ill? YES NO
2. Have you ever been hospitalized? YES NO
3. Have you ever had a major operation? YES NO
4. Have you had a physical exam in the past year? YES NO
5. Have you ever had to take antibiotics before having dental work YES NO
6. Are you being treated now for any condition? YES NO
7. Are you presently taking any medication? YES NO
   If so, Please list____
8. Have you lost or gained weight in the past months? YES NO
9. Have you had, or been told that any of the following conditions pertain to you?

High Blood Pressure	YES	NO	Venereal Disease	YES	NO
Rheumatic Fever	YES	NO	Jaundice	YES	NO
Arthritis	YES	NO	Heart Murmur	YES	NO

Diabetes	YES	NO	Tuberculosis	YES	NO
Anemia	YES	NO	Herpes	YES	NO
Stroke	YES	NO	Hepatitis	YES	NO
Asthma/Hay Fever	YES	NO	Kidney Disease	YES	NO
Hives/Skin Rash	YES	NO	Epilepsy	YES	NO

10. Are you Allergic to or have you had unusual reactions to the following?
    Erythromycin Sulfonamides Aspirin Barbituates
    Penicillin Codeine Iodine Latex Amoxicillin Metal Allergy

11. Have you had a reaction to dental anesthetic? YES NO
12. Do you have sinus trouble? YES NO
13. Have you had x-rays for a tumor, growth or other conditions? YES NO
14. Do you have chest pains on exertion? YES NO
15. Are you nervous? YES NO
16. Have you ever had a bad dental experience? YES NO
17. Have you ever had a blood transfusion? YES NO
18. Have you been or suspect that you have been in contact with the AIDS/HIV virus? YES NO

ABOU T YOUR MOUTH

19. When was your last dental cleaning?_________Where?_____________________
    Were XRays taken? YES (date______) NO May we take them if needed?______
20. Do you usually see your dentist every 6 months? ___________________________
21. Do you use a hard, medium, or soft toothbrush? _____________________________
22. Do you floss your child's teeth? ____
23. Do you have fluoride in the water or supplements? _________________________
24. Have you ever had orthodontic or appliances in the mouth? __________________
25. Have you ever had periodontal (gum) treatment? __________________________

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge. Our office policy requires that **PAYMENT** be made as services are rendered unless a prior arrangements are made. I consent to any use of intraoral pictures on my child for educational purposes.

Parent/Guardian_____________________________Date___________________