

# WELCOME

## Your Child's Very Own Dentist

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## Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

### 1. Tell Us About Your Child

Child's Name \_\_\_\_\_  
Last First Mi

Nickname \_\_\_\_\_  Male  Female

Siblings that we treat \_\_\_\_\_

Child's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age \_\_\_\_\_

Child's Home # (\_\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_



Child's Home Address: \_\_\_\_\_

\_\_\_\_\_ APT. / CONDO #

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### 2. Mother's Information

Name \_\_\_\_\_

 Stepmother  Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_



Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 3. Father's Information

Name \_\_\_\_\_

 Stepfather  Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_



Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_



Marital Status  Single  Married  Separated

 Widowed  Divorced

### 4. Who is Accompanying the Child Today?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

### 5. Person Responsible for Account

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

### 6. Primary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

### 7. Secondary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

## 8. Dental History

Is this your child's first visit to the dentist? \_\_\_\_\_

If not, how long since the last visit to the dentist? \_\_\_\_\_

Were any x-rays taken at previous dental visits? \_\_\_\_\_

Have there been any injuries to the teeth, face or mouth? \_\_\_\_\_

\_\_\_\_\_

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why did you bring the child to the dentist today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the child have any of the following habits?

Y  N Lip Sucking / Biting       Y  N Nail Biting

Y  N Nursing Bottle Habits       Y  N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work?       Yes       No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Is the child's water fluoridated?       Yes       No

Is the child taking fluoride supplements?       Yes       No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)?       Yes       No

Does the child brush his/her teeth daily?       Yes       No

Floss his / her teeth daily?       Yes       No

## 10. Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents; any additional charges/fees incurred on any balance including and not limited to collections, legal and late fees which may be up to 40%.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials \_\_\_\_\_ Date \_\_\_\_\_

## 9. Health History

Has the child ever had any of the following conditions?

Y  N Abnormal Bleeding       Y  N Handicaps/Disabilities

Y  N Allergies to any Drugs       Y  N Hearing Impairment

Y  N Any Hospital Stays       Y  N Heart Murmur

Y  N Any Operations       Y  N Hemophilia

Y  N Asthma       Y  N Hepatitis

Y  N Cancer       Y  N HIV + / AIDS

Y  N Congenital Heart Disease       Y  N Kidney/Liver Conditions

Y  N Convulsions/Epilepsy       Y  N Rheumatic/Scarlet Fever

Y  N Pregnancy       Y  N Allergies to Latex Product

Please discuss any serious medical conditions the child has had

\_\_\_\_\_

\_\_\_\_\_

Please list all drugs the child is currently taking \_\_\_\_\_

\_\_\_\_\_

Please list all drugs the child is allergic to \_\_\_\_\_

\_\_\_\_\_

Child's Physician \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Is the child currently under the care of a physician?       Yes       No

Please describe the child's current physical health...

 **Good**       **Fair**       **Poor**

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.**

Who may we thank for referring you to our office? \_\_\_\_\_

\_\_\_\_\_