Welcome

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Pediatric Dentistry

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Health History Form

Today's Date: _____

NOTE: 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)

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate ___/___/___ Child's Age _____

School _____

Child's Home # (___) _____

SS# _____

Child's Home Address: _____

_____ (City / State / Zip)

Email Address: _____

2. Who may we thank for referring you to our office?

_____

3. Mother's Information

Name _____

Mother ☐ Stepmother ☐ Guardian ☐ Birthdate ___/___/___

Employer _____

Work # (___) _____ Ext. _____

Home # (___) _____

Cellular Phone # (___) _____

SS # _____ DL# _____

4. Father's Information

Name _____

Father ☐ Stepfather ☐ Guardian ☐ Birthdate ___/___/___

Employer _____

Work # (___) _____ Ext. _____

Home # (___) _____

Cellular Phone # (___) _____

SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

_____ (City / State / Zip)

Home # (___) _____

Work # (___) _____

Cellular # (___) _____

E-mail _____

7. 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 _____

8. 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 _____

9. Dental History

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

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

Previous Dentist's Name

Were any x-rays taken at previous dental visits?

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. 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 Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorders
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + / AIDS
Y N Congenital Birth Defects	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Diabetes

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.

11.

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date _____/_____/_____

○ Parent or Guardian
○ Other