

Welcome

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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 _____

Stepother 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

9. Health History

Has the child ever had any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease/Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Blood Disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N HIV + / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Conditions |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Latex Product |
| <input type="checkbox"/> Y <input type="checkbox"/> N Seizures/Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Trait/Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> 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**

Who may we thank for referring you to our office? Please circle

Yellow Pages Website Friend Dr. _____

Other _____

10.

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental 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. I also authorize the dental staff to perform the necessary dental service my child may need.

Signature of Parent or Guardian

The Parent or Guardian who accompanies the child is responsible for payment of time of service unless prior arrangements have been approved.