



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 _____ Grade _____

Child's Home # (_____) _____

SS# _____

Child's Home Address: _____

City State Zip

2. Who May We Thank for Referring You?

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate ____/____/____

Email Address: _____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepmother Guardian Birthdate ____/____/____

Email Address: _____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

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? _____

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 Thumb / Finger Sucking Y N Nail Biting

Y N Pacifier Y N Lip Sucking / Biting

Y N Nursing / Bottle Habits Y N Grinding

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 ADD / ADHD

Y N Disabilities / Special Needs

Y N Anemia

Y N Epilepsy / Seizure Disorder

Y N Auto Immune Disease

Y N Hearing Impairment

Y N Asthma / Reactive Airway

Y N Heart Murmur

Y N Autism Spectra

Y N Heart Problems

Y N Behavioral Disorder

Y N HIV + / AIDS

Y N Bleeding Disorder

Y N Kidney/Liver Conditions

Y N Cancer

Y N Pregnancy

Y N Celiac Disease

Y N Reflux

Y N Developmental Delays

Y N Rheumatic / Scarlet Fever

Y N Diabetes

Y N Sensory Processing Disorder

Please discuss or add any medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all ALLERGIES _____

Please list any Hospital Stays or Operations _____

Child's Physician _____

Phone (_____) _____

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

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date

Relationship to Patient

For Office Use Only

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

Initials _____ Date _____

Doctor's Comments _____
