

## 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.

### 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 \_\_\_\_\_

### Mother's Information

Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ If applicable:  
 Stepmother  Guardian

Employer \_\_\_\_\_

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

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

Cell Phone # (\_\_\_\_\_) \_\_\_\_\_

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

### Father's Information

Name \_\_\_\_\_

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

Employer \_\_\_\_\_

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

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

Cell Phone # (\_\_\_\_\_) \_\_\_\_\_

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

Patient's Parent(s):  Single  Married  Separated

Widowed  Divorced

### Who is Accompanying the Child Today?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

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

### Person Responsible for Account

Name \_\_\_\_\_

Relationship \_\_\_\_\_

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

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

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

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

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

### 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 \_\_\_\_\_

### 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 \_\_\_\_\_

**Dental History**

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

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

Where? \_\_\_\_\_

Were any x-rays taken at previous dental visits? **Y N**

Have there been any injuries to the teeth, face or mouth? **Y N**

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** Pacifier Use **Y N** Nail Biting

**Y N** Take a Bottle at Night **Y N** Thumb/Finger Sucking

**Y N** Breastfed

**Y N** Unfavorable Dental Visits

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

\_\_\_\_\_

Is the child's water fluoridated? **Y N**

Is the child taking fluoride supplements? **Y N**

Has the child ever had any pain or tenderness in his/her jaw/

joint? (TMJ/TMD)? **Y N**

Does the child brush his/her teeth daily? **Y N**

Floss his / her teeth daily? **Y N**

I certify that my child is covered by \_\_\_\_\_ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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. I hereby authorize direct payment to my dentist for dental benefits otherwise payable to me.**

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

Date \_\_\_\_\_

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



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

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

Insurance Verification: **Effective Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Preventive** \_\_\_\_\_% **Deductible** \$ \_\_\_\_\_

**Basic** \_\_\_\_\_% **Maximum** \$ \_\_\_\_\_

**Major** \_\_\_\_\_% **Electronic Claims** **Yes No**

**Health History**

Child's Name: \_\_\_\_\_

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 \_\_\_\_\_

Is the child currently under the care of a physician for any ongoing condition? **Y N**

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.**

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does insurance cover sealants (1351)? **Yes No**

If yes, what do they fall under? \_\_\_\_\_