Welcome

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COSMETIC & GENERAL DENTISTRY

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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_____

Nickname_____ Male Female

Child's Birthdate ____/____/____ Child's Age _____

Child's Home # (_____) _____

Child's Home 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# (_____) _____

Cell# (_____) _____

Email: _____

4. Father's Information

Name_____

Father Stepfather Guardian Birthdate___/___/___

Employer_____

Work# (_____) _____Ext. _____

Home# (_____) _____

Cell# (_____) _____

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 _____

_____

Home# (_____) _____

Work# (_____) _____Ext. _____

Cellular # (_____) _____

Email: _____

7. Primary Dental Insurance

Insurance Co. Name_____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

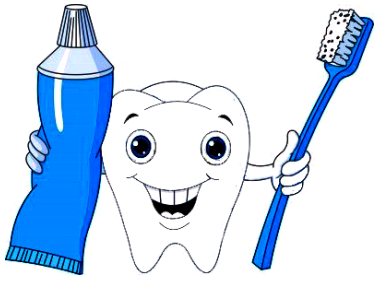
Name _____

Relationship to Patient_____

Birthdate ____/____/____

Social Security # _____

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? _____

Where 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

Y N Clenching or grinding of teeth

Y N Bad breath and/or unpleasant taste

Y N Unfavorable dental experience

Y N Orthodontic treatment Y N Mouth breathing

Y N Cheek biting

Y N Cigarette, pipe, cigar smoking or chewing tobacco

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**?

Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Liver Disease
☐	☐	Alcohol/Drug Abuse	☐	☐	Low Blood Pressure
☐	☐	Anemia	☐	☐	Lupas
☐	☐	Angina Pectoris	☐	☐	Mitral Valve Prolapse
☐	☐	Artificial Bones/Joints/Valves	☐	☐	Osteoporosis
☐	☐	Arthritis	☐	☐	Pneumocystitis
☐	☐	Asthma	☐	☐	Pre-Medicate
☐	☐	Blood Transfusion	☐	☐	Psychiatric Problems
☐	☐	Cancer/Chemotherapy/Radiation	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Colitis	☐	☐	Seizures
☐	☐	Diabetes	☐	☐	Diabetes
☐	☐	Difficulty Breathing/Emphysema	☐	☐	Shingles
☐	☐	Epilepsy	☐	☐	Sickle Cell Disease
☐	☐	Fainting Spells	☐	☐	Sinus Problems
☐	☐	Frequent Headaches	☐	☐	Stroke
☐	☐	Glaucoma	☐	☐	Thyroid Problems
☐	☐	Heart Conditions	☐	☐	Tuberculosis (TB)
☐	☐	Hemophilia	☐	☐	Ulcers
☐	☐	Hepatitis A, B, C	☐	☐	Venereal Disease
☐	☐	High Blood Pressure	☐	☐	Yellow Jaundice
☐	☐	HIV / AIDS	☐	☐	
☐	☐	Kidney Problems	☐	☐	

Y	N	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

For females only

Is your child pregnant? Y N

If yes, what month? _____

Is your child taking birth control pills? _____

Describe any medical treatment and current medications.

_____

Child's Physician _____

Phone (_____) _____

10.

I understand that the information I have given is correct to the best of my knowledge, 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.

11. Consent For Financial Responsibility

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless financial arrangements have been made. I further understand that a one and one half percent 1 ½ % month service charge (18% annually) will be added to any balance over 60 days. In the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

By signing below, I hereby give permission to this office to release any radiographs and records that may be necessary to my insurance company and any referring doctors. I acknowledge receipt of the notice of privacy practices.

If you need to change your appointment time or date, a 24 hour notice is requested to avoid any additional fees.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____