

Patient ID# _____

Today's Date _____

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name _____
 Nickname _____ Sex _____
 Birthdate _____ Age _____
 SS#/SIN _____
 School _____ Grade _____
 Child's Home Address _____
 City _____
 State/Prov. _____ Zip/P.C. _____
 Phone _____

Responsible Party

Name _____
 Relationship _____
 Address _____
 SS#/SIN _____
 DL# _____
 Email _____

Mother

Stepmother Guardian

Name _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 SS#/SIN _____
 Employer _____
 Occupation _____
 DL# _____

Father

Stepfather Guardian

Name _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 SS#/SIN _____
 Employer _____
 Occupation _____
 DL# _____

Primary Dental Insurance

Insured's Name _____
 Relationship _____
 Birthdate _____ SS#/SIN _____
 Employer _____ Date Emp. _____
 Occupation _____
 Ins. Company _____ Group # _____ Emp. # _____
 Ins. Company Address _____
 Deductible _____ Amount already used _____ Max. annual benefit _____
 Orthodontic coverage Yes No

Additional Insurance

Insured's Name _____ Relationship _____
 Birthdate _____ SS#/SIN _____ Employer _____
 Date Emp. _____ Occupation _____
 Ins. Company _____ Group # _____ Emp. # _____
 Ins. Company Address _____
 Deductible _____ Amount already used _____
 Max. annual benefit _____

Parent's Marital Status

- Single Divorced
 Married Widowed
 Separated

Orthodontic coverage
 Yes No

Who is responsible for making appointments?

Name _____
 Home Phone _____
 Work Phone _____ Ext. _____
 Cell Phone _____
 Best time to call (Time) _____ (Days) _____

Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

- Has your child had difficulty with previous visits? _____
- Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? _____
- Has your child ever taken Fen-Phen/Redux? _____
- Has your child ever had any of the following:
- | | |
|---|--|
| Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatic Fever <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO | Congenital Heart Defect <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hepatitis <input type="checkbox"/> YES <input type="checkbox"/> NO | Handicaps/Disabilities <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HIV/AIDS <input type="checkbox"/> YES <input type="checkbox"/> NO | Convulsions/Epilepsy <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hemophilia <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO | Abnormal Bleeding <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Allergies <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Murmur <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please explain any medical problems that your child has

Child's Habits

- How often does your child brush? _____
- How often does your child floss? _____
- Date of last dental visit _____
- Previous Dentist _____
- Child's Physician _____
- Phone Number _____
- Child's Birthdate _____
- Is your child's water fluoridated? YES NO
- Does your child take fluoride supplements? YES NO
- Does your child:
- Suck thumb/finger YES NO
- Suck/Bite lips YES NO
- Bite/Chew nails YES NO
- Chew hard objects
(Pencils, etc.) YES NO
- Grind Teeth YES NO
- Clench Jaws
 YES NO

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental 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 other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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.

X _____
Signature of patient or parent/guardian if minor

Date

Date _____
Comments _____

Signature _____
Date _____

Date _____
Signed Dr. _____

Comments _____
Signature _____

Health History Update