Pediatric dental arts home
making your child's smile a work of art!

Health History Form

TODAY'S DATE: _____

Child's Information

Child Name: _____ Nickname: _____
First M. Last

Child's Address:

_____

Child's Date of Birth: _____ Age: _____ M [ ] F [ ]

Sibling that we treat _____

Child's Favorite (Hobbies, TV Shows, Pets etc) _____

Whom should we thank for the referral to our office? _____

Parent #1 Information

Parent's Name: _____
First M. Last

Relationship to patient: _____

Date of Birth: _____

SSN # _____

Employer: _____

Work: (_____) _____

Home:(_____)_____

Cell: (_____) _____

Home Address: _____

_____

_____

E-mail Address: _____

Please provide us with the best way you may be contacted: Phone call [ ] Text message [ ] E-mail [ ]

_____

Parent #2 Information

Parent's Name: _____
First M. Last

Relationship to patient: _____

Date of Birth: _____

SSN # _____

Employer: _____

Work: (_____) _____

Home :(_____)_____

Cell: (_____) _____

Home Address: _____

_____

_____

E-mail Address: _____

Please provide us with the best way you may be contacted: Phone call [ ] Text message [ ] E-mail [ ]

_____

Who is accompanying the child today?

Name: _____

Relationship: _____

Who is responsible for Payment? _____

How do you plan to pay for your child's visit?
VISA [ ] MasterCard [ ] Check [ ] Cash [ ]

Insurance Information

Insurance Name _____

ID#: _____ Group#: _____

Policy Holder's Name: _____

Relationship with patient: _____

(Please present your card at time of the first visit)

MEDICAL HISTORY

Physician Name & Address: _____ Physician's Phone: _____

_____ Date of last medical Exam: _____

Are your child's immunizations up to date? No( ) Yes( )

If no, please explain: _____

Please review carefully and check the appropriate boxes if your child has any history, or condition related to, any of the following:

[ ] ADD/ADHD
[ ] Anemia
[ ] Asthma
[ ] Arthritis/Joint problems
[ ] Autism
[ ] Behavioral problems
[ ] Bladder/Kidney problems
[ ] Bleeding Disorders/transfusion
[ ] Bone Disorders
[ ] Cancer
[ ] Cerebral Palsy
[ ] Chronic Sinusitis
[ ] Cold sores/canker sores
[ ] Communication problems
[ ] Congenital birth defects
[ ] Cystic Fibrosis
[ ] Diabetes
[ ] Pre-med required prior to dental visit
[ ] Dizziness
[ ] Eating disorder (anorexia/bulimia)
[ ] Enlarged Tonsils
[ ] Epilepsy
[ ] Fainting
[ ] Frequent headaches
[ ] Growth problems
[ ] Hearing loss
[ ] Heart murmur
[ ] Heart trouble
[ ] Hepatitis
[ ] High blood pressure
[ ] HIV/ AIDS
[ ] Infections
[ ] Latex Allergy
[ ] Learning disorders
[ ] Limitations of use of arms or legs
[ ] Other _____
[ ] Liver problems
[ ] Muscle Weakness/Muscular Dystrophy
[ ] Nerve disorders
[ ] Pregnancy (for teens)
[ ] Premature at birth
[ ] Rheumatic Fever
[ ] Seizures
[ ] Sensory problems
[ ] Severe/prolonged bleeding
[ ] Sickle Cell Disease
[ ] Skin problems/rashes
[ ] Speech impairment
[ ] Stomach/intestinal problems
[ ] Thyroid problems
[ ] Tuberculosis
[ ] Unintentional weight loss
[ ] Vision disorders
[ ] None

If you have checked any of the boxes above (other than none), please explain: _____

_____

_____

Please list **ALL** allergies that your child may have. This includes food, medications, etc. _____

_____

_____

Is your child currently taking medication (prescription or over the counter)? If yes, please list all:
Medication: Dosage: Times per day:

_____

_____

Has your child ever received radiation therapy (X-ray treatments) or is it planned? No[ ] Yes[ ]
Has your child ever received chemotherapy or is it planned? No[ ] Yes[ ]

Has your child ever been hospitalized? No[ ] Yes[ ]
If yes: Hospital _____
Date of visit: _____
Reason: _____

DENTAL HISTORY

Does your child have a toothache or any other immediate dental problem? No ( ) Yes ( )
Has your child ever had a toothache? No ( ) Yes ( )
Has your child ever had an injury to the mouth? No ( ) Yes ( )
Is this your child's first dental visit? No ( ) Yes ( )
If No,
Last date of visit :_____
Dentist: _____
Reason: _____

Has your child ever had an unfavorable dental experience? No ( ) Yes ( )
Was your child nourished by nursing beyond the age of one? No ( ) Yes ( )
If Yes, Please check: Breast: _____, Nursing Bottle____
Both: _____, to what age? _____

Does your child fail to eat a well balanced diet? No ( ) Yes ( )
If yes, what foods or food groups are not adequate?
_____

Does your child have any other oral habits? If yes, please check: No ( ) Yes ( )
Thumb(s): _____Finger(s): _____ Pacifier_____
Lip Biting: _____ Mouth: _____ Nail: _____
Breathing: _____ Biting: _____ Grinding: _____
Others: _____
_____
_____
_____

Does your child have difficulty opening his or her mouth, or does the child's jaw sometimes locks or stick in certain positions? No ( ) Yes ( )

Does your child have popping or clicking noises or pain during chewing or yawning? No ( ) Yes ( )

Does your child have frequent headaches or pain in or about the ears, eyes, or cheeks? No( ) Yes ( )

Does your child snore at night or mouth breath? No( ) Yes ( )

Dental Health Information

How often does your child brush? _____per day

Does your child use dental floss? No ( ) Yes ( )

Does someone assist your child with brushing and cleaning their teeth? No ( ) Yes ( )
Does your child use fluoride toothpaste? No ( ) Yes ( )

Has your child ever had a fluoride treatment? No ( ) Yes ( )

Has your child ever taken a fluoride supplement or vitamins with fluoride? No ( ) Yes ( )
If Yes, **Dosage** _____

Does your child use a fluoride rinse? No ( ) Yes ( )

Please note any special needs or comments we should know in order to better care for your child.
_____
_____
_____

Is your child experiencing any of the following - dry cough, runny nose, sore throat, watery eyes, sinus pain/pressure that is unusual and not related to seasonal allergies, headaches, fatigue, weakness, loss of taste and/or smell? Yes/No
If yes, please explain: _____

I understand this information is necessary to provide my child or me with dental care in a safe and efficient manner. I certify that the above information is complete and accurate to the best of my knowledge.

Parent/ Guardian's Signature: _____ Date: _____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photograph, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for the above named patient is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that 1 ½ finance charge (18% annually) will be added to my balance over 45 days. In the event of default I promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Parent/ Guardian's Signature: _____ Date : _____

THE PARENT/GUARDIAN/CAREGIVER WHO BRINGS THE PATIENT IN FOR TREATMENT IS RESPONSIBLE FOR ALL FEES INCURRED AT THE TIME SERVICES ARE RENDERED.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, _____have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

(You may refuse to sign this acknowledgement and authorization. In refusing, we **may not be allowed** to process your insurance claims.)

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For Office Use Only

We attempted to obtain written acknowledgement of receipt our Notice of Privacy Practices but acknowledgement could not be obtained because:

- Individual Refused to Sign: _____
- Communication barriers prohibited obtaining the acknowledgement: _____
- An emergency situation prevented use from obtaining acknowledgement: _____
- Other: _____