PEDIATRIC DENTAL/MEDICAL HISTORY FORM

TELL US ABOUT YOUR CHILD **Today's Date**:_____

Child's Name:_____ Nickname:_____ [] Male [] Female
LAST FIRST MI

Birth Date:___/___/_____ Age: ____ School: _____Grade:_____

Child's Home #: (___) _____ SS#: _____

Child's Home Address: _____
STREET CITY STATE ZIP

WHO IS ACCOMPANYING THE CHILD TODAY?
Name: _____ Relation: _____

Do you have legal custody of this child? []Yes []No Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____ Last Visit Date: _____

Parent's Marital Status: []Single []Married []Divorced []Separated []Widowed

MOTHER OF CHILD []Step Mother []Guardian

Name: _____
Birthdate: ___/___/___ Cell Ph:_____
Hm Ph: _____Wk Ph: _____
Employer:_____ Email:_____
SS#: _____ DL#: _____

FATHER OF CHILD []Step Father []Guardian

Name: _____
Birthdate: ___/___/___ Cell Ph:_____
Hm Ph: _____Wk PH: _____
Employer:_____Email:_____
SS#: _____ DL#: _____

PERSON RESPONSIBLE FOR ACCOUNT

Billing:
Name: _____ Relation: _____ SS#: _____ DL#: _____
LAST FIRST MI
Billing Address: _____
STREET CITY STATE ZIP
Home #: (____)_____ Employer: _____ Work #: (____) _____

Appointments:
Name: _____ Hm # (___)_____ Wk #: (____)_____
LAST FIRST MI

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____
Group # **(Plan,Local, or Policy #):** _____
Address: _____
Phone #: ( ) _____

Policy Owner Name: _____
Relationship to Patient: _____
Birthdate: ___/___/___
SS#: _____ Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____
Group # **(Plan,Local, or Policy #):** _____
Address: _____
Phone #: ( ) _____

Policy Owner Name: _____
Relationship to Patient: _____
Birthdate: ___/___/___
SS#: _____ Employer: _____

WHAT IS THE PRIMARY REASON FOR THE CHILD'S APPOINTMENT?

Reason for first visit:

_____

_____

Has the child ever had a serious/difficult problem associated with previous dental treatment? []Yes []No
Is the child's water fluoridated? []Yes []No
Is the child taking fluoridated supplements? []Yes []No
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? []Yes []No
Does the child have headaches, neck pain or balance problems? []Yes []No
Does the child brush his/her teeth daily? []Yes []No
Does the child floss (or someone) his/her teeth daily? []Yes []No
Child's Physician: _____ Phone: (__) _____ Last Visit: ___/___/___
Is the child currently under the care of a physician?
Please describe the child's current physical health: []Good []Fair []Poor
Please list all drugs that the child is currently taking: _____

_____

Please list all drugs/materials that the child is allergic to: _____

_____

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Abnormal Bleeding	[]Yes []**N**o	Congenital Heart Defect	[]Yes []**N**o	Hemophilia	[]Yes []**N**o
Drug Allergies	[]Yes []**N**o	Convulsions/Epilepsy	[]Yes []**N**o	Hepatitis	[]Yes []**N**o
Any Hospital Stays	[]Yes []**N**o	Diabetes	[]Yes []**N**o	HIV+/AIDS	[]Yes []**N**o
Any Operations	[]Yes []**N**o	Handicaps/Disabilities	[]Yes []**N**o	Kidney/Liver	[]Yes []**N**o
Asthma	[]Yes []**N**o	Hearing Impairment	[]Yes[]**N**o	Rheumatic/Scarlet Fever	[]Yes []**N**o
Cancer	[]Yes []**N**o	Heart Murmur	[]Yes []**N**o	Tuberculosis	[]Yes []**N**o

Please discuss any serious medical problems that the child has had: _____

_____

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Lip Sucking/Biting	[]Yes []No	Nail Biting	[]Yes []No
Nursing Bottle Habits	[]Yes []No	Thumb/Finger Sucking	[]Yes []No

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 that 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: ____/____/____

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.