

Health History

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Has your child had difficulty with previous visits?

Yes No If yes, explain _____

Please explain any medical problems that your child has:

Is your child receiving medication. Yes No If so, what?

Is your child allergic to any medication. Yes No
If so, what?

Has your child ever had any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions/Epilepsy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Speech Impairments |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Previous Surgery |
| <input type="checkbox"/> Behavioral/Learning Problems | |
| <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Congenital Heart Defect | |
| <input type="checkbox"/> Handicaps/Disabilities | |

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.

Signature of parent or guardian: _____

Date: _____

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

How long since your last dental visit? _____

Were any x-rays taken at the last visit? Yes No

Previous Dentist: _____

Child's Physician: _____

Phone Number: _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Eat between meals? Yes No

Suck thumb/finger? Yes No

Bite/Chew nails? Yes No

Chew hard objects (pencils, etc.) Yes No

Grind teeth? Yes No

Clench jaws? Yes No

Health Update

Comments: _____

Signature: _____ Date: _____

Comments: _____

Signature: _____ Date: _____

Comments: _____

Signature: _____ Date: _____

Welcome

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.

Today's Date: _____

Your Child:

Child's Legal Name: _____ Nickname: _____ Male Female

Birth Date: _____ Age: _____ School: _____ Grade: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Mother

Stepmother Guardian

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employer: _____

Occupation: _____

DL#: _____

Father

Stepfather Guardian

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Employer: _____

Occupation: _____

DL#: _____

Responsible Party

Name: _____

Relationship: _____

Address: _____

DL#: _____

Parent's Marital Status

Single Divorced Married Widowed Separated

Primary Dental Insurance

Insured's Name: _____ D.O.B. _____ Social Security #: _____

Relationship to child: _____ Insured address (if different from child): _____

Employer: _____ Date Employed: _____ Occupation: _____

Insurance Company: _____ Group #: _____ SSN / ID#: _____

Insurance Company Address: _____

Comments:

Pediatric Dentistry · Dr. Elaine Martinez