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Health History & Patient Demographic Form

Child's Full Name _____ Nickname _____
Sex: M _____ F _____ Birthdate _____ Adoption/Guradianship _____
Is this the child's first dental visit? _____ Date of last visit _____ Purpose _____
Name of child's pet _____ Child's interests _____ Name of School or pre-school? _____
Name of family dentist _____ Child's previous dentist _____
What is the reason for this visit? _____
How did you hear about our office? _____

GENERAL INFORMATION

FATHER (full name) _____ Date of birth _____ Marital Status _____
Home address _____ City/State _____ Zip _____
Home phone _____ Cell phone _____ Work Phone _____
Employer _____ Address _____ City/Zip _____
SS# _____ Driver's License Number _____ Email _____

MOTHER (full name) _____ Date of birth _____ Marital Status _____
Home address _____ City/State _____ Zip _____
Home phone _____ Cell phone _____ Work Phone _____
Employer _____ Address _____ City/Zip _____
SS# _____ Driver's License Number _____ Email _____

Child resides with: Both parents _____ Caregiver _____ Other _____
Name of nearest relative not living with you (relationship) _____
Address _____ City/Zip _____ Home Phone _____

DENTAL INSURANCE INFORMATION

Father: Name of Insurance Company _____ Group/Policy No. _____
Address _____ Phone number _____ Ins. ID # _____

Mother: Name of Insurance Company _____ Group/Policy No. _____
Address _____ Phone number _____ Ins. ID # _____

Assignment of Benefits: I hereby authorize payment directly to the above named dentist of the group dental benefits otherwise payable to me but not to exceed the charges shown on the claim. I understand that I am financially responsible for 100% of all charges and any charges not covered by this authorization.

All balances past due 60 days are subject to a finance charge of 1 1/2% per month (an annual rate of 18%) and / or subject to all legal and collection expenses.

Signature _____ Date _____
Parent / Guardian



MEDICAL INFORMATION

Child's Pediatrician _____ Phone number _____ Date of last physical exam _____

Is your child under a doctor's care now? _____ For What Reason? _____

What medicines or drugs is your child taking? _____

Reason _____

Has your child ever been hospitalized? _____ When _____ Reason? _____

What medications is your child allergic to? _____ Reaction _____

Does your child have allergies to: food _____ animals _____ pollen _____ dust _____ latex _____ other _____

Does your child have good physical coordination? _____

Has your child's developmental milestones been attained? _____ Are your child's immunizations up to date? _____

Has your child had a history or difficulty with any of the following:

- Grid of medical conditions with Y/N columns: Anemia, Asthma, Autism, Bleeding Problems, Bone Disorder, Brain Injury, Bruising, Cancer/Malignancies, Cerebral Palsy, Chronic Congestion, Chronic Cough, Diabetes, Earaches (chronic), Fainting/Dizziness, Gag Reflex, Hearing Difficulties, Heart Murmur, Heart Problems, Hepatitis, High Blood Pressure, High Fevers, HIV/AIDS, Immune Disorder, Kidney Problems, Liver Problems, Mental Disorder, Motion Sickness, Nosebleeds, Physical Disorder, Premature Birth, Reflux/Regurgitation, Rheumatic Fever, Seizures, Speech Disorder, Stomach Problems, TB/Lung Disease, Thyroid/Adrenal Disease, Redux/Phenpen, Bisphosphates/Fosmax, Other issues.

Dental Information

Was your child bottle fed? _____ Until what age? _____ Breast fed? _____ Until what age _____

Does your child have any oral habits, such as finger/thumb sucking _____ pacifier _____ nail biting _____

Lip sucking _____ mouth breather _____ snoring _____ tooth grinding _____ other _____

Has your child ever had any injuries to the teeth, mouth or head? _____

If yes, please describe _____

Has your child taken fluoride? _____ In what form and when _____

Does your child brush regularly? _____ Floss regularly? _____ Does an adult assist? _____

Has either parent or child been treated orthodontically (braces)? _____

How would you expect your child to behave in our office? _____

Describe your child: Outgoing _____ Shy _____ Stubborn _____ Anxious _____ Frightened _____

How may we help make this visit a positive experience for your child? _____

AUTHORIZATION & 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 also authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I further acknowledge the receipt of the Dental Materials Fact Sheet dated October 2001 and HIPPA Privacy Form.

Signature _____ Date _____
Parent / Guardian