



PEDIATRIC HEALTH HISTORY

Date _____
 Child 's Name _____ Age _____ Birthdate _____
 Whom may we thank for referring this patient? _____
 Date of last dental visit _____ With Whom _____
 Explain briefly why you brought your child for dental care: _____

Because your child is a minor, your signature as a parent or guardian must be obtained to authorize any necessary dental service. I hereby grant such authorization, and shall accept responsibility for any and all fees incurred for such dental service.

Signature _____

Family physician or pediatrician _____
 Date of last medical examination _____
 Name of nearest relative not living with you _____
 Relative's Home Phone # _____ Relative's Work Phone # _____

Has your child had any of the following? Please indicate with a checkmark.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Kidney/Liver | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Allergies to medicines/
drugs | <input type="checkbox"/> Contagious disease | <input type="checkbox"/> Oral herpes | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Allergies to _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Sinus Problems |
| _____ | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> HIV Virus | | |

Is your home supplied by well water? Yes No

Does your child have health problems that require the active care of a physician? Yes No

Is your child presently taking any medications? Yes No

Has your child ever been hospitalized? Yes No

Reason _____

Do you consider your child to be progressing normally? Yes No

If not explain _____

OFFICE USE ONLY – MEDICAL HISTORY UPDATE

Date	No Change	Change	Date	No Change	Change	Date	No Change	Change
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

PATIENT INFORMATION

Date _____ Birthdate _____ Male Female

Patient's Name _____
LAST FIRST MIDDLE NICKNAME

Address _____
STREET CITY STATE ZIP

Custodial Parent's Name _____ Home Phone _____

Have any of this patient's siblings been to our office: Yes No

If yes, please list name(s) _____

PARENT INFORMATION

Name _____ Marital Status _____

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____

Spouse's Name _____ Marital Status _____

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insured's Name _____ Birthdate _____

Insured's ID # _____ Employer _____

Insurance Company _____ Group No. _____

Insurance Company Address _____

Insurance Company Phone Number _____

Secondary Insurance

Insured's Name _____ Birthdate _____

Insured's ID # _____ Employer _____

Insurance Company _____ Group No. _____

Insurance Company Address _____

Insurance Company Phone Number _____

Payment for services is required at the time of visit. We will complete your insurance form if requested; however, the account must be cleared within 30 days. For your convenience, we accept cash, checks, money orders, MasterCard or Visa. Please feel free to discuss your child's treatment and fees with our office.

I have read the above policy. Yes No