MEDICAL HISTORY

Child's name: _____ Nickname: _____
Date of birth: _____ Phone number: _____
Home address: _____
Street City State Zip code
Father's name: _____ Employment: _____
Father: _____
Date of birth dd/mm/yyyy Home Phone # Work Phone # Cell phone # (May we text?) Other phone #
Mother's name: _____ Employment: _____
Mother: _____
Date of birth dd/mm/yyyy Home Phone # Work Phone # Cell phone # (May we text?) Other phone #
Person(s) responsible for bill: _____
Address: _____ Phone: _____
Street City State Zip code
Child's primary dental insurance coverage: _____
Insurance Information: ID# _____ Group # _____
Child's secondary dental insurance coverage: _____
Insurance Information: ID# _____ Group # _____
Child SSN: _____ Mother SSN: _____ Father SSN: _____
Child's physician(s): _____ Phone: _____
Is your child receiving treatment by a physician? _____
If yes, for what is he/she being treated?_____
Is your child now taking medications? _____ Reason: _____
Prescription medications: _____ Non-prescription medications: _____
Has your child had any of the following? _____ Please check all that apply.

____Rheumatic fever	____Liver disease	____Latex Allergy
____Scarlet fever	____Hepatitis	____Chronic Disease(s)
____Heart disease	____Diabetes	____Musculo-Skeletal Disorder(s)
____Heart murmur	____Seizure(s)	____Developmental Disorder(s)
____Respiratory disorders	____Emotional disorder(s)	____Frequent colds
____Tuberculosis	____Bleeding problems	____Speech disorder(s)
____Asthma	____Anemia	____Other _____

Are your child's immunizations up to date? _____ yes _____ no
Have you been told antibiotics are recommended for your child's dental appointments? _____ yes _____ no
Other healthcare concerns or other information: _____
_____
_____
Is your child allergic to any anesthetics? _____
Any other allergies? _____ Medicine or drug allergies? _____
Has your child taken penicillin? _____ Unfavorable reaction? _____
Has your child been hospitalized overnight? _____
If yes, when and why? _____
Has your child been put to sleep with a general anesthetic? _____
Were there any complications? _____
Were there any complications during pregnancy, delivery, or the first year of life? _____
If yes, please describe: _____
_____
_____
Names and ages of brothers and sisters: _____
_____
Pets: _____ Hobbies: _____
Interests: _____
Comments: _____

Yes No

___ ___ Do you know if your water supply is fluoridated? Concentration: _____

___ ___ Has your child had fluoride supplements prescribed? By whom: _____

___ ___ Has your child had fluoride treatment in school?

___ ___ Has you child had fluoride treatment in a dental office?

___ ___ Have dental x-rays been made of your child's teeth?

If yes, approximate date of the most recent ones:

Bitewings: _____

Panoramic: _____

Are current legible copies available for our use today? _____

Comments: _____

_____

Is this your child's first visit to a dentist? _____

If not, who was your child's former dentist(s)? _____

How did you learn of this office (who referred you)? _____

Reason for referral: _____

Comments: _____

If this is not the first visit, how were previous visits tolerated by your child? _____

_____

How do you think he/she will react in the dental environment? _____

_____

How would you describe your child's temperament? _____

_____

Is there now, or has there ever been, any of the following?

____Cavities ____Toothache ____Dental pain ____Broken teeth ____Traumatized teeth

Is there now, or has there ever been, any of the following?

____Breaths through the mouth ____Suck thumb(s) and / or fingers(s) _____Pacifier use

____Bites fingernails ____Bites or sucks lips _____Blanket use with oral habit

____Tongue habits ____Other habits affecting mouth or teeth

How often and when does your child brush his/her teeth? _____

How often do his/her teeth get flossed? _____

Does he/she brush alone or with assistance? _____

Do you have any particular concerns about your child's dental health you would like addressed by the dentist or staff? _____

_____

_____

Insurance coverage is an agreement between the insurance company and my family. As a courtesy to families, this office will complete insurance claim forms at every visit which will promptly be submitted or provided for my use. Balances not paid by insurance coverage are due when the professional services are rendered.

I am (we are), and will continue to be until further written notice, responsible for payment for the charges for the professional services rendered for this child. In the event the account becomes delinquent (90 days and over), a finance charge of 18% (1½ % per month) will be added to the account. In the event the account is turned over to a collection attorney, I agree to be responsible for an attorney fee equal to 33.333% of the outstanding balance due on the date the account is turned over for collection. In the event the account becomes delinquent and it becomes necessary to expend costs for the collection of the account, I understand that I will be responsible for the costs. These costs could include court costs for filing suit against me.

I give my permission for my child to be examined and treated now and at such times when I bring or send him or her to this office or other location for dental care.

Printed Name: _____Signed: _____ Date: _____

Printed Name: _____Signed: _____ Date: _____