HEALTH HISTORY

Patient's name: ___________________________ **Name of legal guardian(s)**: ____________________________

Birthdate: ______________________ **Height**: ___________________ **Weight**: ______________________

Child's physician: __________________________________ **Physician's phone number**: ____________________

□ **Yes** □ **No** Is your child in good health?

□ **Yes** □ **No** Are their immunizations up to date?

□ **Yes** □ **No** Has there been any change in their health in the past year?

□ **Yes** □ **No** Have they ever been hospitalized or required surgery?

□ **Yes** □ **No** Has there been any recent increase or decrease in thirst or appetite?

□ **Yes** □ **No** Has you child had an allergic reaction to medicine or foods?

□ **Yes** □ **No** Does your child require an antibiotic prior to dental treatment?

Please indicate any of the following that your child has/has had:

□ Heart murmur
□ Congenital heart lesions
□ Damaged/artificial heart valves
□ Other heart conditions
□ Asthma
□ Respiratory problems
□ Diabetes
□ Kidney disease or dialysis
□ Liver disease
□ Arthritis/painful swollen joints
□ Anemia
□ Bleeding problems
□ Bruise easily
□ Mononucleosis
□ Cancer or tumor
□ Thyroid condition
□ Congenital disorder
□ Genetic disorder
□ Immune disorder
□ Psychiatric disorder
□ Neurological disorder
□ Seizure disorder
□ Mental/physical delays
□ Autism
□ Sensory integration disorder
□ ADHD

Please describe any other medical problems not listed above:

____
____
____

Young women:
□ **Yes** □ **No** Is your daughter taking birth control pills?
□ **Yes** □ **No** Is your daughter pregnant?

Please list any prescription and over-the-counter medications and what they are taken for:

Medication	**What is it taken for?**

I certify that I have read and understand the above medical history questionaire. To the best of my knowledge, all of the preceding health history answers I have given are true and correct. If my child ever has any health changes, I will inform the doctors at the next appointment without fail.

Signature: ____ **Date:** ____________________________________

Relationship to patient: ____
Dates Reviewed:

DENTAL HISTORY

Patient's Name (and Nicknames): ____

Was your child: □ Breast fed □ Bottle fed □ Combination At what age was it stopped? _______________

Does/Did your child sleep with a bottle: □ Yes □ No At what age was it stopped? _____________________

If currently bottle feeding, what is fed from the bottle?
□ Formula □ Milk □ Water □ Juice □ Other ____________________________________

Daily milk intake: ____

Daily juice/soda/sports drink intake: ____

How often does your child eat snacks? _____ times per day

Has your child ever been to the dentist? □ Yes □ No
If Yes, Name of Dentist and Date: ____

Has your child experienced an unfavorable reaction from previous dental care? □ Yes □ No
If Yes, please explain: ____

Does either parent have a history of cavities? □ Yes □ No

Does you child have siblings with cavities □ Yes □ No

Who brushes your child's teeth? ____

How many times a day does your child brush? ____

Does your child floss regularly? □ Yes □ No

Has your child ever injured his/her teeth or gums? If yes, please explain:

____

Does your child's jaw make noise and is pain associated with the sounds?

____

Does your child wear a mouth guard for sports? □ Yes □ No

Does your child suck a finger, thumb, or pacifier? □ Yes □ No

Have you noticed that your child grinds his/her teeth?
If yes, how often? ____

FLUORIDE:
Is your home water supply fluoridated? □ Yes □ No
Does your child use fluoride toothpaste? □ Yes □ No
Do you give your child any other types of fluoride, such as rinses or vitamins? □ Yes □ No
If yes, please describe: ____

Do you have any concerns about your child's teeth?
____
____

PATIENT REGISTRATION

Date: ________________

Name: ________________________________ Preferred Nickname: _________________________

Birthdate: ____________________________ Sex: Male ☐ Female ☐

With whom does the child primarily reside? ☐ Mother ☐ Father ☐ Both ☐ Other __________

Address: Email:

____________________________________ ____

____

____

Mother's Name: ____________________________ Father's Name: ____________________________

Home phone: _______________________________ Home Phone: ______________________________

Cell phone: ________________________________ Cell phone: _______________________________

Work phone: _______________________________ Work phone: ______________________________

School/Preschool: ___________________________

Siblings name (and ages): ____

Hobbies, Pets, Favorite Toys: ____

Do you have any concerns about your child's first appointment? ☐ Yes ☐ No

____

____

Person Responsible for Payment:

Name: ________________________________

Relationship: ___________________________

Dental Insurance:

Do you have dental insurance? __________________

How did you hear about our office? ____

When available, by which method(s) would you prefer to be contacted for appointment reminders, etc.?

- ☐ Email
- ☐ Phone call (at ☐ home ☐ cell ☐ work)
- ☐ Text message
- ☐ Mail

☐ I authorize you to discuss my child's appointment times and treatment with:

___ grandparents

___ anyone who brings them to appointments

___ other ____________________________________

☐ I do not want my child's appointment times or treatment discussed with anyone.

Signature: ____ **Date**: ______________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for the payment for all dental services. This office will help prepare the patients' insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service fee of 1.5% per month (18% per annum) will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of patient examination, and treatment costs could vary from the estimate provided if additional treatment needs are discovered.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to the doctor, or her assignee, at the time services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I grant my permission to you, or your assignee, to telephone me at home, on my cell phone, or at my work to discuss matters related to this form.

____   ____________________

Signature   Date