MEDICAL HISTORY QUESTIONAIRE

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 their 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? If so, why? _____

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 12 years of age and older:

□ **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: _____

Dates Reviewed:

DENTAL HISTORY

Patient's Name (and Nicknames): _____

Daily milk intake: _____

Daily juice/soda 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: _____

Has your child had cavities in the past? □ Yes □ No

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

Does your 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 chlid 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 other 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: _____

Does your child have problems with:

☐ concentrating? ☐ learning? ☐ cooperating? ☐ understanding?

Do you think your child will be a cooperative patient? ☐ 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