Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has the child ever had a serious/difficult problem associated with previous dental work? □ Yes □ No

Is the child's water fluoridated? □ Yes □ No

Is the child taking fluoridated supplements? □ Yes □ No

Has the child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? □ Yes □ No

Does the child brush his/her teeth daily? □ Yes □ No

Does the child floss his/her teeth daily? □ Yes □ No

Previous Dentist: ______________________

Date of last dental visit: ______________________

Child's Physician: ______________________

Office Address: ______________________

City: ____________ State: ________ Zip: ________

Office Ph. #: ____________ Date of last visit: ________

Is the child currently under the care of a physician? If so, what is he/she being treated for? ______________________

Please describe the child's current physical health:

□ Good □ Fair □ Poor

Please list all drugs that the child is currently taking: ______________________

Please list all drugs/materials that the child is allergic to: ______________________

Has the child ever had any of the following medical problems (please circle):

Y N Abnormal Bleeding	Y N Diabetes
Y N Allergies to any drugs	Y N Handicaps/Disabilities
Y N Allergies Nuts/Peanuts	Y N Hearing Impairment
Y N Allergies to Red Dyes	Y N Heart Murmur
Y N Any hospital stays	Y N Hemophilia
Y N Any Operations	Y N Hepatitis
Y N Asthma	Y N HIV+/AIDS
Y N Cancer	Y N Kidney/Liver Problems
Y N Congenital Heart Defect	Y N Rheumatic/Scarlet Fever
Y N Convulsions/Epilepsy	Y N Tuberculosis (TB)

Please list any serious medical problems that the child has had: ______________________

Child's Habits:

Y N Lip Sucking/Biting	Y N Chew/Bite Nails
Y N Suck thumb/finger	Y N Lip Sucking/Biting
Y N Chew hard objects	Y N Grind Teeth
Y N Nursing or Bottle Habits	Y N Clench jaws

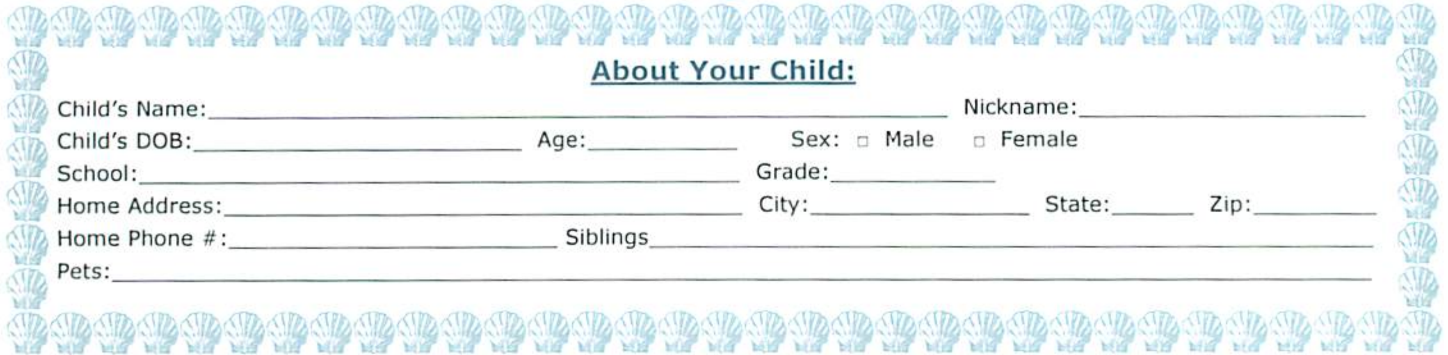
Authorization and Release:

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 authorize the dentist to release any information; including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ______________________

Signature of parent/guardian

Growing Smiles



About Your Child:

Child's Name:______________________________ Nickname:______________

Child's DOB:________________ Age:________ Sex: □ Male □ Female

School:______________________________ Grade:________

Home Address:______________________ City:____________ State:______ Zip:________

Home Phone #:________________ Siblings______________________________

Pets:____

Who Is Accompanying The Child Today?

Name:______________________________

Relationship to child:______________________

Do you have legal custody of this child? □ Yes □ No

Whom may we thank for referring you?________________

____

Other family members seen in our office: ______________

____

Is there a specific reason for today's visit? ____________

____

____

Parent's Marital Status: □ Single □ Widowed □ Separated

□ Married □ Divorced

Mother's Information: □ Step Mother □ Guardian

Name: ________________ DOB: ______________

Wk # (   )____________ x___ Hm. #:______________

Employer:______________________________

SS#:______________ DL#: ______________

Father's Information: □ Step Father □ Guardian

Name:________________ DOB: ______________

Wk#:________________ x___ Hm.#:______________

Employer: ______________________________

SS:________________ DL#: ______________

Account Holder Information:

Name:________________ Relation:______________

Billing Address:______________________________

City:____________ State:__________ Zip:________

Hm.#: ________________ Wk.#:________________

Who is responsible for making appointments?

Name:______________________________

Wk.#: ____________ x ______ Hm.#: ______________

Primary Dental Insurance:

Insurance Co. Name:______________________

Ins. Co. Address:______________________

Ins. Co. Ph. #: ______________________

Group # (Plan, Local or Policy #): ______________

Policy Holder's Name: ______________________

DOB: ________________ SS#: ______________

Policy Holder's Employer: ______________________

Orthodontic Coverage: □ Yes □ No

Secondary Dental Insurance:

Insurance Co. Name:______________________

Ins. Co. Address:______________________

Ins. Co. Ph. #: ______________________

Group # (Plan, Local or Policy #): ______________

Policy Holder's Name:______________________

DOB: ________________ SS#: ______________

Policy Holder's Employer: ______________________

Orthodontic Coverage: □ Yes □ No