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