Dentistry
for Children and Adolescents
PEDIATRIC SPECIALISTS

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Please Note: We DO NOT file Third Insurances.

Health History Form

For your convenience... fill out this online form, print and bring with you to your appointment.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Nickname_____ Male Female

Siblings that we treat _____

Child's Birthdate_____

Child's Home # _____

Cellular Phone # _____

Child's Home Address: _____
APT. / CONDO #

_____
City State Zip

Who does child live with? Parent 1 Parent 2

Email:_____

2. Parent 1 Information

Name _____

Step Parent Guardian DOB:_____

Email:_____

Home Address (if different)

_____

Employer _____

Work # _____ Ext. _____

Home # _____

Cellular Phone # _____

SS # _____

Marital Status ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced

3. Parent 2 Information

Name _____

Step Parent Guardian DOB:_____

Email:_____

Home Address (if different)

_____

Employer _____

Work # _____ Ext. _____

Home # _____

Cellular Phone # _____

SS # _____

Marital Status ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced

4. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

The parent or guardian who accompanies the child is responsible for payment at the time of service.

Please Note: The parent whose birthday falls first in the year (month) is primary, unless there is a divorce decree or legal document.

5. Person Responsible for Account

Name _____

Relationship _____

Billing Address

_____
City State Zip

Home # _____

Work # _____

6. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address

_____

Insurance Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____

Social Security # _____

Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address

_____

Insurance Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____

Social Security # _____

Policy Owner's Employer _____

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8. Dental History

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

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth?

_____

If yes, please explain:

Why did you bring the child to the dentist today?

Does the child have any of the following habits?

☐Y ☐N Lip Sucking / Biting ☐Y ☐N Nail Biting

☐Y ☐N Nursing Bottle Habits ☐Y ☐N Thumb / Finger Sucking

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

If yes, please explain:

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

Is the child taking fluoride 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

Floss his/her teeth daily? ☐Yes ☐No

9. Health History

Has the child ever had any of the following problems? Circle Y or N

☐Y ☐N Abnormal Bleeding
☐Y ☐N Allergies to any Drugs/Food (List Below)
☐Y ☐N Acid Reflux
☐Y ☐N Any Hospital Stays
☐Y ☐N Any Operations
☐Y ☐N Asthma
☐Y ☐N Cancer
☐Y ☐N Congenital Heart Disease
☐Y ☐N Convulsions/Epilepsy
☐Y ☐N Pregnancy
☐Y ☐N Autistic
☐Y ☐N Diabetes
☐Y ☐N Handicaps/Disabilities
☐Y ☐N Hearing Impairment
☐Y ☐N Heart Murmur (Doctors Letter Required)
☐Y ☐N Hemophilia
☐Y ☐N Hepatitis
☐Y ☐N HIV + / AIDS
☐Y ☐N Kidney/Liver Problems
☐Y ☐N Rheumatic/Scarlet Fever
☐Y ☐N Allergies to Latex Product
☐Y ☐N ADHD
☐Y ☐N Other (List Below)

Please discuss any serious medical problems the child has had:

Please list all drugs the child is currently taking:

Please list all drugs/foods the child is allergic to:

Child's Physician _____

Phone _____

Is the child currently under the care of a physician? ☐Yes ☐No

Please describe the child's current physical health...

☐Good ☐Fair ☐Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Whom may we thank for referring you to our office?

_____

10. PARENT ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that the information provided on this form is accurate and that the person who brings this child to Dentistry for Children is the legal guardian of this child. Whoever accompanies this child on subsequent visits has my express permission to consent to treatment. If this child should come for a subsequent visit unaccompanied, I hereby consent to treatment. I acknowledge that as the legal guardian, I am responsible for full payment of all charges including a broken appointment charge of $40 when appointments are missed without notice. I hereby authorize my insurance benefits to be paid to the undersigned dentist. I understand that any balance not paid within 60 days - regardless of outstanding insurance - incurs a finance charge of 1.5% per month (18% annually). If my account is referred to a collection agency or law firm to collect the unpaid balance, I understand and agree that I will be responsible for paying all collections costs, including but not limited to, reasonable attorney fees and court costs. I have received a copy of Dentistry for Children's Notice of Privacy Practices.

As an insurance cardholder, it is important that you as the patient are aware of your insurance benefits. Our office recommends that you confirm your insurance coverage prior to your appointment. This will help eliminate any insurance concerns once treatment has begun. **PLEASE UNDERSTAND** that we file dental insurance as a courtesy to our patients.

By my eSignature verification below, I verify that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures. Pursuant to section 11.100 of Title 21 of the Code of Federal Regulations, this is to certify that to confirm that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

_____ _____

Signature of Parent/Legal Guardian Date Relationship to Patient

_____

Printed Name of Parent/Legal Guardian