Dental/Medical Health History (Confidential)

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

Patient ID # _____

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of Last Dental Visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Has your child ever had any of the following:

Acid Reflux	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Food Allergies	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Describe _____		
Hemophilia/Abnormal Bleeding	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses When?

_____ _____

_____ _____

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

_____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

☐ _____

AUTHORIZATION & 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 also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my 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.

_____ _____

Signature of Patient (or Parent/Guardian if minor) Date

Dentist's Review: _____

_____

_____

_____

_____

_____

Signature of Dentist Date