Welcome

Health History Form

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For your convenience… Print this form, complete all information, and bring it with you on your first visit to our office. The Parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Nickname _____ Male Female

Siblings that we treat _____

Child's Birth date ____/_____/_____ Child's Age _____

Child's Home # (_____)_____

Child's Home Address _____

_____
Apt./Condo

_____
City State Zip

How did you hear about us? _____

(Please let us know so we can thank them)

2. Mother's Information

Name _____

Stepmother Guardian Birth date ____/_____/_____

Employer _____

Occupation _____

Work # (_____)_____ Ext._____

Home #(_____)_____

Cellular Phone #(_____)_____

3. Father's Information

Name _____

Stepfather Guardian Birth date ____/_____/_____

Employer _____

Occupation _____

Work # (_____)_____ Ext._____

Home # (_____)_____

Cellular Phone # (_____)_____

Parental Marital Status:

❑ Single ❑ Married ❑ Separate
❑ Widowed ❑ Divorced

4. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

5. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

_____
City State Zip

Home # (_____)_____

Work # (_____)_____ Ext._____

E-Mail _____

6. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone #(_____)_____

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

Policy Owner's Name _____

Policy Owner's Birth date _____/_____/_____

Social Security # _____-_____-_____

Member ID # _____

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 _____

Policy Owner's Birth date _____/_____/_____

Social Security # _____-_____-_____

Member ID # _____

Policy Owner's Employer _____

Child's Name _____

Dental History

Is this your child's first visit to the dentist? YES NO

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

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

Any injuries to the teeth, face or mouth? YES NO

If yes, explain _____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Name of previous dentist *(if applicable)* _____

Was the previous dental experience positive? YES NO

If no, explain _____

_____

_____

Does the child have any of the following habits?

- ❑ Thumb/ finger sucking
- ❑ Uses a bottle
- ❑ Uses a pacifier
- ❑ Grinds teeth

Does the child brush his/ her teeth daily? YES NO

Does the child floss his/ her teeth daily? YES NO

Does the child use a mouthwash daily? YES NO

Health History

Has the child ever had any of the following conditions?

Y N	Asthma	Y N	Handicaps/ Disabilities
Y N	Diabetes	Y N	Hearing Impairment
Y N	ADD/ ADHD	Y N	Skin Disorder
Y N	Heart Problem/ Disease	Y N	Hepatitis/ Liver Condition
Y N	Convulsions/ Epilepsy	Y N	Kidney Condition
Y N	Congenital Birth Defects	Y N	Rheumatic/ Scarlet Fever
Y N	Hemophilia/ Bleeding Disorder	Y N	Anemia
Y N	Tuberculosis	Y N	Sickle Cell Disease/ Traits
Y N	Cancer	Y N	HIV+/ AIDS
Y N	Pregnancy	Y N	Drug/ Alcohol Abuse

Are the child's immunizations current? YES NO

Any hospitalizations or operations? YES NO

If yes, describe _____

_____

List all medications the child is currently taking _____

_____

_____

List all MEDICATIONS and OTHER SUBSTANCES the child is allergic to (i.e. penicillin, latex, peanuts) _____

_____

Please describe any serious medical condition, medical treatment including drugs, pending surgery, recent injuries, or any other information not yet discussed _____

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this 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 health practitioners. I authorize and request my insurance company to pay directly to the dentist 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. I also authorize the dental staff to perform the necessary dental service my child may need.

_____

Signature of Parent or Guardian Date

The parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

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Northwest Children's Dentistry