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Health History Form

Tell Us About Your Child

Child's Name _____

Last First MI

Male **Female**

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

Child's Home # (_____)_____

Child's Home Address _____

_____ (Apt/ Condo)

_____

City *State* *Zip*

Siblings that we treat _____

Email Address for appointment confirmations:

_____

Guardian's Information

Name_____

Birth date ____/_____/_____

Employer_____

Occupation _____

Cellular Phone # (_____)_____

Other Phone # (_____)_____

Guardian's Information

Name_____

Birth date ____/_____/_____

Employer _____

Occupation _____

Cellular Phone # (_____)_____

Other Phone # (_____)_____

Primary Dental Insurance

Insurance Co. Name_____

Policy Owner's Name_____

Policy Owner's Birth date _____/_____/_____

Member ID # _____

Social Security # _____-_____-_____

Policy Owner's Employer _____

Secondary Dental Insurance

Insurance Co. Name_____

Policy Owner's Name_____

Policy Owner's Birth date _____/_____/_____

Member ID # _____

Social Security # _____-_____-_____

Policy Owner's Employer _____

How did you hear about our office?

Google Insurance Facebook Pediatrician Friend

_____

(Please write the name of who referred you)

PLEASE TURN OVER AND COMPLETE THE BACK SIDE

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

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? _____

Name of previous dentist *(if applicable)* _____

Was the previous dental experience positive? YES NO

If no, explain _____

_____

Why did you bring your child to the dentist today?

_____

_____

_____

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	Cancer	Y N	HIV+/ AIDS
Y N	Tuberculosis	Y N	Sickle Cell Disease/ Traits
Y N	Pregnancy	Y N	Drug/ Alcohol Abuse

Are the child's immunizations current? YES NO

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

_____

_____

Health History Continued

Any hospitalizations or operations?

If yes, describe _____

_____

_____

_____

Does your child take any medication/ supplements?

If yes, please list _____

_____

_____

_____

Is your child **ALLERGIC** to any **MEDICATIONS** or **OTHER SUBSTANCES?** (i.e. Penicillin, latex, peanuts, etc.):

If yes, please list _____

_____

_____

Childs Pediatrician _____

Northwest Children's Dentistry

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.