



New Patient Health History Form

Date: _____

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

Child Information:

Child's Name: _____
Last First MI
Goes by: _____ Male Female
Siblings that we treat: _____
Child's Birthdate: ____ / ____ / ____ Child's Age: ____
School: _____ Grade: ____
Child's Home #: (____) _____
SS#: _____
Child's Home Address: _____

Mother's Information:

Name: _____
 Mother Stepmother Guardian Birthdate: ____ / ____ / ____
Employer: _____
Home Address: _____

Work #: (____) _____ Ext: ____
Home #: (____) _____
Cell #: (____) _____
SS#: _____ DL#: _____
Email Address: _____

Father's Information:

Name: _____
 Father Stepfather Guardian Birthdate: ____ / ____ / ____
Employer: _____
Home Address: _____

Work #: (____) _____ Ext: ____
Home #: (____) _____
Cell #: (____) _____
SS#: _____ DL#: _____
Email Address: _____

Who is Accompanying the Child Today?

Name: _____
Relationship: _____
Do you have legal custody of this child: Yes No

Person Responsible for Account

Name: _____
Relationship: _____
Billing Address: _____
_____ City State Zip
Work #: (____) _____ Ext: ____
Home #: (____) _____
Cell #: (____) _____
Email Address: _____

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: _____

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: _____



New Patient Health History Form

Dental History

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

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

Previous Dentist's Name: _____

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? Y N

If yes, please explain: _____

Is the child's water fluoridated? _____ Y N

Is the child taking fluoride supplements? _____ Y N

Has the child ever had any pain or tenderness in his/her jaw joint (TMJ / TMD)? _____ Y N

Does the child brush his/her teeth daily? _____ Y N

Floss his/her teeth daily? _____ Y N

Health History

Has the child ever had any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Disabilities / Special Needs |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease / Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Blood Disorders |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N HIV + / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Birth Defects | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney / Liver Conditions |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/ Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Latex Product |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD / ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Autism |

Please discuss any serious medical conditions the child has had: _____

Please list all drugs the child is currently taking: _____

Please list all drugs the child is allergic to: _____

Child's Physician: _____

Phone: (_____) _____

Is the child currently under the care of a physician? Y N

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.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. **I authorize the dental staff to perform the necessary dental services my child may need.**

Signature of Parent or Guardian

Date

Relationship to Parent

+++++ FOR OFFICE USE ONLY +++++

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: _____

Initials _____ Date _____