Pediatric Dentistry

Health History Form

Today's Date: _____

1. Tell Us About Your Child

Child's Name _____
Last First MI

Preferred Name: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate _____/_____/_____ Child's Age _____

Social Security # _____

Child's Home # (_____)_____

Child's Home Address:_____

_____
City State Zip

Email:_____

Who has custody of the child? _____

2. Confirming Appointments Information

We like to call and personally confirm all appointments with patient's guardian. Please provide us with a phone number to reach you at and the best time to call those phone numbers. **PLEASE NOTE:** In the event your phone number gets disconnected or changes, please notify us immediately! If we fail to reach you due to a disconnected phone or changed phone number your appointment may be canceled.

Cell phone: _____ Text Y/ N

Home/ Other Phone:

Relationship to Patient _____

Best Time to Call: _____

3. Consent for Treatment

Please list any persons you authorize to bring your child to the office for dental treatment. Also, list each person's relationship to the patient. Each person that you list must be able to provide us with accurate medical history and you certify that you will update these individuals of any medical changes relating to your child when they bring them to our office for treatment.

_____

_____

_____

_____

4 Health History

Has the child ever had any of the following conditions?

Y N	Bleeding Disorders	Y N	Hearing Impairment
Y N	Allergies to any Drugs	Y N	Heart Murmur
Y N	Any Hospital Stays		sbe needed? _____
Y N	Any Operations	Y N	Hemophilia
Y N	Asthma	Y N	Hepatitis
Y N	Cancer	Y N	HIV + / AIDS
Y N	Congenital Heart Disease	Y N	Kidney/Liver Conditions
Y N	Convulsions/Epilepsy	Y N	Rheumatic/Scarlet Fever
Y N	Pregnancy	Y N	Allergies to Latex Product
Y N	ADD/ADHD	Y N	Diabetes
Y N	Handicaps/Disabilities	Y N	Other

If any answered yes above, please explain.

_____

_____

Please list all drugs the child is currently taking (explain) _____

_____

Please list all drugs 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 recommending you to our office?

_____

5

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 Patient

WILD SMILES
Pediatric Dentistry

6. Mother's Information

Name _____

Birthdate _____/_____/_____ SS# _____

Address _____

_____

Home # (_____)_____

Cell # (_____)_____

Employer _____

Work # (_____)_____ Ext. _____

DL# _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

7. Father's Information

Name _____

Birthdate _____/_____/_____ SS# _____

Address _____

_____

Home # (_____)_____

Cell # (_____)_____

Employer _____

Work # (_____)_____ Ext. _____

DL# _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

8. Primary Dental Insurance

Policy Owner's Employer _____

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

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

ID # _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

9. Secondary Dental Insurance

Policy Owner's Employer _____

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

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

ID # _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

10

I certify that the above insurance information is accurate and correct and my child/children do not have any other dental insurance other than what I have provided your office with. I understand that although whether this office is considered "in network" or "out of network" with my insurance company they will gladly file my insurance services rendered however, they will not file or re-file any claim after 6 months from the date that services were rendered if I fail to make the office aware of new or additional insurance coverage or if insurance fails to pay due to additional information they require from the policy holder. I understand failure to disclose any additional insurance or any inaccurate insurance information of any kind could result in the entire balance becoming my sole responsibility.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient