PATIENT HISTORY FORM

Patient Information

Patient Name: _____
Preferred Name: _____

Age: _____ Gender: M / F Date of Birth _____

Address: _____

Is this your child's first dental visit? If no, when was the last visit?

_____

Do you have well water at home? _____
Has your child bumped any teeth? If so, when? _____

Has your child had history of headaches, popping, or clicking of the jaw? _____
Does your child still have a nighttime bottle? _____
Does your child have a toothache? If so, how long? ____

Does your child have any of the following habits? Please indicate how long and if it is an active habit.
Thumb Sucking: _____
Finger Habit: _____
Pacifier: _____

How often does your child brush? _____
Are they supervised and by whom? _____
Is dental floss used? _____

Does your child receive:

- ☐ Fluoride tablets/drops
- ☐ Fluoridated water
- ☐ Fluoride in vitamins
- ☐ Bottled water
- ☐ Well water

Please list any siblings to the patient listed above that will be attending our practice: _____

_____

Emergency Contact

Name/Relationship: _____
Phone Number: _____

Responsible Party Information

Names of Legal Guardians and relationship:
1._____
Relationship: _____
2._____
Relationship: _____

Address if different than the Patient's listed to the left:

_____

_____

Preferred Phone number for confirmations:
Home or Cell (circle one):

_____

Other Number:

_____

Email address for confirmations (confidential):

_____

Insurance Company: _____
Group or Plan Number: _____
Employer: _____
Policy Holder (Employee): _____
Date of Birth: _____SSN: _____
Subscriber # _____

Secondary Insurance: _____
Group or Plan Number: _____
Employer: _____
Policy Holder (Employee): _____
Date of Birth: _____SSN: _____
Subscriber # _____

Financial Information

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees and applicable court costs in addition to my outstanding balance. I hereby authorize the practice to receive the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

SIGNATURE: _____

PATIENT HISTORY FORM

Patient Medical History

Family Physician's Name: _____

_____

Address: _____

Phone Number: _____

Is your child under the care of a physician for other than routine care? Explain. _____

_____

Please list any **drug** allergies your child may have: ____

_____

_____

Please list any **other** allergies your child may have: ____

_____

_____

Please list any medications your child is currently taking, daily/as needed, prescription or over the counter and why:

_____

_____

_____

Has your child ever been hospitalized or had surgery for any reason, including emergency or scheduled treatment, please list when and for what reason: _____

_____

_____

_____

Has your child been diagnosed with any emotional, intellectual, mental, nervous, or behavioral disorders? Please explain.

_____

_____

_____

Please list any specialists, outside of your family physician, that your child sees. Please include their office and contact information: _____

_____

Please indicate if your child has been diagnosed with any of the following conditions:

- ☐ ADD / ADHD
- ☐ Anemia / Sickle Cell Anemia
- ☐ Asthma / Reactive Airway
- ☐ Austim
- ☐ Bleeding or Blood Disorder
- ☐ Cerebral Palsy
- ☐ Cleft Lip / Palate
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Endocrine Disorder
- ☐ Epilepsy / Seizures
- ☐ Heart Condition
- ☐ Hepatitis / Liver Problems
- ☐ H.I.V
- ☐ Malignancies / Cancer / Leukemia
- ☐ Pregnancy
- ☐ Positive TB Test
- ☐ Stomach / Intestinal Disorder
- ☐ Other: _____

Please explain any conditions checked above so that we can treat your child safely. _____

_____

_____

Please list any specialists, outside of your family physician, that your child sees. Please include their office and contact information: _____

_____

Photo Release

I hereby authorize the practice to use and/or publish still or video photography of _____ (patient name) on printed materials or in electronic formats, including on the internet for the purpose of promoting or advertising the practice. I may revoke this authorization at any time by informing the practice, and understand that signing this release is not required to receive treatment.

SIGNATURE: _____

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia and routine dental treatment with use of proper and acceptable methods to complete the same. I accept responsibility for payment of services rendered for my child, _____. I understand I will be informed of any treatment other than routine dental treatment before it is performed.

SIGNATURE OF LEGAL GUARDIAN: DATE: