

## Health History

### 1. Patient's Information

Name \_\_\_\_\_  
Last First MI

Nickname \_\_\_\_\_ Gender Male / Female

Birth date \_\_\_\_\_ Age \_\_\_\_\_

Social Security # \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City State ZIP

### 2. Mother's Information

Name \_\_\_\_\_  
Last First MI

Birth date \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City State ZIP

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_

### 3. Father's Information

Name \_\_\_\_\_  
Last First MI

Birth date \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City State ZIP

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_

4. Email address: \_\_\_\_\_

### 5. Emergency Contact (other than parents)

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

### 6. Referral Information

Who may we thank for recommending our office to you?

\_\_\_\_\_

Referrer's relationship to you \_\_\_\_\_

### 7. Person Responsible for Account

Name \_\_\_\_\_  
Last First MI

Billing Address \_\_\_\_\_

\_\_\_\_\_

City State ZIP

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

### 8. Primary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

\_\_\_\_\_

City State ZIP

Insurance Co. Phone (\_\_\_\_\_) \_\_\_\_\_

Group/Plan/Policy# \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Policy Owner Soc. Sec.# \_\_\_\_\_

Policy Owner Birth date \_\_\_\_\_

### 9. Secondary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

\_\_\_\_\_

City State ZIP

Insurance Co. Phone (\_\_\_\_\_) \_\_\_\_\_

Group/Plan/Policy# \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Policy Owner Soc. Sec.# \_\_\_\_\_

Policy Owner Birth date \_\_\_\_\_

## 10. Dental History

First Visit to a Dentist? YES NO

Previous Dentist \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of previous radiographs (xrays) \_\_\_\_\_

What is the main reason for your dental visit today?

How do you think your child will react to today's visit?

Please answer the following questions regarding the patient:

- YES NO Pre-term birth?  
YES NO Frequent Childhood illnesses?  
YES NO Injury to teeth, mouth, or face?  
YES NO Oral habits (e.g. finger sucking, nail biting)?  
YES NO Drinking water from tap?  
YES NO Taking fluoride supplement?  
YES NO Popping, clicking, or pain with jaw joint?  
YES NO Difficulty with previous dental treatment?  
YES NO Brush teeth daily?  
YES NO Fluoride in toothpaste?  
YES NO Floss teeth daily?  
YES NO More than one snack of sugary drink/food each day?  
YES NO History of nighttime feeding?  
YES NO Parent or sibling with cavities?  
YES NO History of smoking in patient's home?

## 11. Physician Information

Patient's Physician \_\_\_\_\_

Physician Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

## 12. Medical History

Please answer the following questions regarding the patient, and if answer is "YES", then explain briefly below:

- YES NO Prior hospitalizations or surgeries?  
YES NO Prior General Anesthesia or Sedation?  
YES NO Taking any medications?  
YES NO Allergy or sensitivity to medications?  
YES NO Allergy or sensitivity to foods/substances?  
YES NO Immunizations up-to-date?  
YES NO Congenital (birth) abnormalities?  
YES NO Infectious disease (measles, chicken pox, HIV)?

Does the patient have any medical condition with the following systems of the body? If so, please explain briefly below.

- YES NO Heart? (murmur, surgery, malformation, high/low blood pressure)  
YES NO Lungs? (asthma, tuberculosis, reactive airway, cystic fibrosis, RSV)  
YES NO Gastrointestinal? (GERD/reflux, hepatitis, jaundice, ulcer, lactose intolerance, dietary restrictions)  
YES NO Genitourinary? (bladder/kidney infections, systemic birth control, pregnancy)  
YES NO Musculoskeletal? (bone/joint problems, arthritis)  
YES NO Skin? (fever blisters, eczema, rash/hives)  
YES NO Neurologic? (autism, developmental delay, seizures, epilepsy, brain injury, cerebral palsy)  
YES NO Psychiatric? (abuse, ADHD, chemical dependency, emotional disturbance)  
YES NO Endocrine? (diabetes, hypothyroid, hormonal problems, growth delay)  
YES NO Hematologic/Lymphatic/Immunity? (anemia, hemophilia, sickle cell, cancer, immune disorder, chemotherapy, radiation therapy)

## 13. Verification of Information

I attest that the information provided above is correct to the best of my knowledge, and it is my responsibility to inform Pediatric Dentistry, P.C., prior to each appointment, of any changes to the above information.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient