

# Welcome

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## Health History Form

**Today's Date:** \_\_\_\_\_

For your convenience...Print this form, complete all information and bring it with you on your first visit to our office

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

### 1. Tell Us About Your Child

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: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address: \_\_\_\_\_

### 2. Who may we thank for referring you to our office?

\_\_\_\_\_

### 3. Mother's Information

Name \_\_\_\_\_

Mother Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

Email: \_\_\_\_\_

### 4. Father's Information

Name \_\_\_\_\_

Father Stepfather Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

Email: \_\_\_\_\_

### 5. Who is Accompanying the Child Today?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

### 6. Person Responsible for Account

Name \_\_\_\_\_

Relationship \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

Cellular # (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

### 7. 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** \_\_\_\_\_

### 8. 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** \_\_\_\_\_

**9. 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?      **Yes**      **No**

If yes, please explain \_\_\_\_\_

Is the child's water fluoridated?      **Yes**      **No**

Is the child taking fluoride supplements?      **Yes**      **No**

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)?      **Yes**      **No**

Does the child brush his/her teeth daily?      **Yes**      **No**

Floss his / her teeth daily?      **Yes**      **No**

**10. Health History**

Has the child ever had any of the following conditions?

Y  N Abnormal Bleeding       Y  N Disabilities/Special Needs

Y  N Allergies to any Drugs       Y  N Hearing Impairment

Y  N Any Hospital Stays       Y  N Heart Disease/Murmur

Y  N Any Operations       Y  N Hemophilia/Blood Disorders

Y  N Asthma       Y  N Hepatitis

Y  N Cancer       Y  N HIV + / AIDS

Y  N Congenital Birth Defects       Y  N Kidney/Liver Conditions

Y  N Convulsions/Epilepsy       Y  N Rheumatic/Scarlet Fever

Y  N Speech Problem       Y  N Allergies to Latex Product

Y  N Tuberculosis       Y  N Diabetes

Y  N ADD/ADHD       Y  N PDD/Autism

Please discuss any serious medical conditions the child has had

\_\_\_\_\_

Please list all drugs the child is currently taking \_\_\_\_\_

\_\_\_\_\_

Please list all allergies \_\_\_\_\_

\_\_\_\_\_

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.***

**11.** I, the undersigned, have completed the health history questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising out of inadequate information not disclosed. I grant authority to Dr. Sangita Madan to perform all procedures and treatments in the patient's best interest.

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

\_\_\_\_\_  
Date

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

***For Office Use Only***

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

Initials \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_