# Child Health History Form

Account Number _____

Today's Date _____

DENTAL HEALTH ASSOCIATES

Trusted Care Since 1972

## ABOUT YOUR CHILD

Child's name: _____ ❑ Female ❑ Male

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

School: _____ Grade: _____

Birth Date: _____/_____/_____ Age: _____

What is your child's favorite sport? _____

Favorite toy? _____ Favorite Hobby? _____

Who can we thank for referring you? _____

Father's name: _____

Cell Phone: _____

Mother's name: _____

Cell Phone: _____

## DENTAL INSURANCE INFORMATION

Primary Insurance company name: _____

Subscriber: _____

Subscriber's birth date: _____ Relationship to Patient _____

Group number: _____

ID number: _____

Social Security number: _____

Employer: _____

Secondary Insurance company name: _____

Subscriber: _____

Subscriber's birth date: _____ Relationship to Patient _____

Group number: _____

ID number: _____

Social Security number: _____

Subscriber employer: _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Dental Health Associates. Guardian's Initials: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Dental History

How do you feel your overall dental health is? _____

Do you have fear of dental procedures? ❍ Yes ❍ No

How do you feel about your smile and the look of your teeth: _____

What is the main reason for your visit today?

Tooth pain ❍ Yes ❍ No
I need a check-up ❍ Yes ❍ No
Cleaning ❍ Yes ❍ No
Orthodontics (braces) ❍ Yes ❍ No
Whitening ❍ Yes ❍ No
Cosmetic dentistry ❍ Yes ❍ No
Sedation dentistry ❍ Yes ❍ No
Other ❍ Yes ❍ No

Are you under a physician's care now? If yes, please provide physician's name and phone number. ❍ Yes ❍ No If yes _____

Have you been hospitalized or had a major operation in the last 2 years? ❍ Yes ❍ No If yes _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes _____

Are you taking any medications, pills or drugs? ❍ Yes ❍ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ Yes ❍ No If yes _____

Do you use tobacco? ❍ Yes ❍ No If yes _____

Do you use any controlled substances? ❍ Yes ❍ No If yes _____

Women: Are you . . .

❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin/Other Antibiotics ❑ Codeine/Other Narcotics ❑ Acrylic
❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthetics
❑ Shellfish, Iodine or Red Wine

If so, list your allergies not listed above. _____

Comments: _____

_____

Do you need to pre-medicate w/antibiotics prior to dental treatment ❍ Yes ❍ No If yes _____

Have you ever had any serious illness not listed ❍ Yes ❍ No If yes _____

Do you have, or have you had in the last 5 years, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ❍ Yes ❍ No | Hemophilia | ❍ Yes ❍ No | Radiation Treatments | ❍ Yes ❍ No | Alzheimer's Disease | ❍ Yes ❍ No |
| Diabetes | ❍ Yes ❍ No | Acid Reflux | ❍ Yes ❍ No | Anaphylaxis | ❍ Yes ❍ No | Drug Addiction | ❍ Yes ❍ No |
| Renal Dialysis | ❍ Yes ❍ No | Anemia | ❍ Yes ❍ No | Easily Winded | ❍ Yes ❍ No | Rheumatic Fever | ❍ Yes ❍ No |
| Angina | ❍ Yes ❍ No | Emphysema | ❍ Yes ❍ No | High Blood Pressure | ❍ Yes ❍ No | Rheumatism | ❍ Yes ❍ No |
| Arthritis/Gout | ❍ Yes ❍ No | Epilepsy or Seizures | ❍ Yes ❍ No | High Cholesterol | ❍ Yes ❍ No | Scarlet Fever | ❍ Yes ❍ No |
| Artifical Heart Valve | ❍ Yes ❍ No | Excessive Bleeding | ❍ Yes ❍ No | Hives or Rash | ❍ Yes ❍ No | Shingles | ❍ Yes ❍ No |
| Artificial Joint | ❍ Yes ❍ No | Excessive Thirst | ❍ Yes ❍ No | Hypoglycemia | ❍ Yes ❍ No | Sickle Cell Disease | ❍ Yes ❍ No |
| Asthma | ❍ Yes ❍ No | Fainting | ❍ Yes ❍ No | Irregular Heartbeat | ❍ Yes ❍ No | Sinus Trouble | ❍ Yes ❍ No |
| Blood Disease | ❍ Yes ❍ No | Frequent Cough | ❍ Yes ❍ No | Kidney Problems | ❍ Yes ❍ No | Blood Transfusion | ❍ Yes ❍ No |
| Leukemia | ❍ Yes ❍ No | Stomach/Intestinal Disease | ❍ Yes ❍ No | Breathing Problems | ❍ Yes ❍ No | Liver Disease | ❍ Yes ❍ No |
| Stroke | ❍ Yes ❍ No | Bruise Easily | ❍ Yes ❍ No | Low Blood Pressure | ❍ Yes ❍ No | Swelling of Lmbs | ❍ Yes ❍ No |
| Cancer | ❍ Yes ❍ No | Glaucoma | ❍ Yes ❍ No | Lung Disease | ❍ Yes ❍ No | Thyroid Disease | ❍ Yes ❍ No |
| Chemotherapy | ❍ Yes ❍ No | Seasonal Allergies | ❍ Yes ❍ No | Mitral Valve Prolapse | ❍ Yes ❍ No | Tonsilitius | ❍ Yes ❍ No |
| Chest Pains | ❍ Yes ❍ No | Heart Attack/Failure | ❍ Yes ❍ No | Osteoporosis | ❍ Yes ❍ No | Tuberculosis | ❍ Yes ❍ No |
| Cold Sores/Fever | ❍ Yes ❍ No | Heart Murmur | ❍ Yes ❍ No | Pain in Jaw Joints | ❍ Yes ❍ No | Tumors or Growths | ❍ Yes ❍ No |
| Congential Heart Disorder | ❍ Yes ❍ No | Heart Pacemaker | ❍ Yes ❍ No | Ulcers | ❍ Yes ❍ No | Convulsions | ❍ Yes ❍ No |
| Heart Trouble/Disease | ❍ Yes ❍ No | Psychatric Care | ❍ Yes ❍ No | Hepatitis A, B or C | ❍ Yes ❍ No | Bacterial Endocarditis | ❍ Yes ❍ No |
| Sleep Apnea | ❍ Yes ❍ No | | | | | | |

The information I have given is true and accurate to the best of my knowledge.

X _____ Date _____