IMPLANT & GENERAL DENTISTRY

Children's Health History Form

We want your child to have a pleasant yet educational visit. Our goal is to teach good oral care that will enable your child to have a beautiful smile that will last a lifetime.

Tell Us About Your Child

Name:

First Last Prefer to be Called

Address: City: State: Zip:

Mailing address

SS#: Home Phone: Include area code ( ) Date of Birth: Sex: M F

Who may we Thank for referring you?

Other family members seen by us:

Previous / Present Dentist:

Parental Information

Mother's Name: Cell Phone: Include area code

First Last ( )

Employer: Work Phone: Include area code

( )

SS# & Drivers License#: Email:

Father's Name: Cell Phone: Include area code

First Last ( )

Employer: Work Phone: Include area code

( )

SS# & Drivers License#: Email:

Parent's Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Person Responsible for the Account: Cell Phone: Include area code: ( )

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: Insurance Co. Address:

Insurance Co. Phone #: Group # (Plan, Local or Policy #): Identification#:

Insured's Name: Relation: Insured's Date of Birth Insured's SS#

Insured's Employer:

Secondary Dental Insurance

Insurance Co. Name: Insurance Co. Address:

Insurance Co. Phone #: Group # (Plan, Local or Policy #): Identification#:

Insured's Name: Relation: Insured's Date of Birth Insured's SS#

Insured's Employer:

Dental Health History

Please mark (X) your response to the following questions.

Is this the patient's first visit to a dentist? ☐ Yes ☐ No

If no, when was the patient's last dental exam?_____What was done at that appointment?_____

When was the last time the patient had dental x-rays taken? What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No If yes, where?_____

Please mark (X) your response to the following questions.

	Yes	No	DK
Has the patient had any problem with dental treatment in the past?	☐	☐	☐
If yes, please describe what happened: _____			
Has the patient had any problems with teeth coming in or losing teeth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well			
Does the patient take fluoride supplements?	☐	☐	☐
Does the patient use fluoride toothpaste when brushing teeth?	☐	☐	☐
How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____			
Has the patient ever worn braces or other orthodontic appliances?	☐	☐	☐
Has the patient ever had a serious injury to the head, mouth or teeth?	☐	☐	☐
If yes, please describe what happened and when it happened: _____			
Does the patient play any contact sports or participate in active recreational activities?	☐	☐	☐
If yes, please describe those activities here: _____			
Does/did the patient use a pacifier or suck his/her thumb or fingers?	☐	☐	☐
At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____			
Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep			

Medical Health History & Vaccination Status

Please mark (X) your response to the following questions.

Please list the name and phone number of the patient's physician:

Doctor's Name: _____Phone:_____

Does the patient see any medical specialists? ☐ Yes ☐ No If yes, please explain. _____

Please use an "X" to mark your answers to the following questions.

	Yes	No	DK	
Is the patient currently being treated for any condition(s) or illness(es)?	☐	☐	☐	If yes, what is the illness and when did it start?
Has the patient ever had a serious illness?	☐	☐	☐	If yes, what was the illness and when did it happen?
Has the patient ever been hospitalized?	☐	☐	☐	When and why?
Has the patient ever been given a general anesthetic?	☐	☐	☐	
Has the patient ever had a blood transfusion?	☐	☐	☐	
Does the patient experience excessive bleeding when cut?	☐	☐	☐	
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist?	☐	☐	☐	If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: _____ Phone: _____
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any genetic (inherited) conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any speech difficulties?	☐	☐	☐	If yes, please explain.

How would you describe the patient's eating habits?

Medical Health History & Vaccination Status

Please mark (X) your response to the following questions.

Is the patient up-to-date with immunizations related to patienthood diseases (tetanus, measles, mumps, etc.)? ☐Yes ☐No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? ☐Immunized ☐Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

☐ ADD/ADHD	☐ Chicken Pox	☐ Hepatitis	☐ Seizures
☐ Alcohol/Drugs	☐ Chronic sinusitis	☐ HIV/AIDS	☐ Sexually transmitted infection (STI)
☐ Anemia	☐ Diabetes	☐ Immunizations	☐ Sickle Cell Anemia
☐ Arthritis	☐ Ear aches	☐ Kidney problems	☐ Thyroid issues
☐ Asthma	☐ Epilepsy	☐ Liver problems	☐ Tobacco/Vaping
☐ Bladder problems	☐ Fainting	☐ Measles	☐ Tuberculosis
☐ Bleeding disorders	☐ Growth problems	☐ Mononucleosis	☐ Other: _____
☐ Bone/Joint issues	☐ Hearing problems	☐ Mumps	_____
☐ Cancer	☐ Heart Issue	☐ Pregnancy (teens)	_____
☐ Cerebral Palsy	☐ Heart Murmur	☐ Rheumatic Fever	_____

Medications & Allergies

Please mark (X) your response to the following questions.

	Yes	No	DK
Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?	☐	☐	☐
If yes, please list them here: _____			
Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?	☐	☐	☐
If yes, please list those medications: _____			
Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.?	☐	☐	☐
If yes, please describe the allergy and the reaction: _____			

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.
I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Patient/Legal Guardian: **Date:**

X

For Completion By Dentist

Comments: _____

Office Use Only: ☐Medical Alert ☐Premedication ☐Allergies ☐Anesthesia

Reviewed by: _____ Date: _____

Welcome: My staff & I appreciate the selection of our office to serve your dental needs. Our goal in this practice is to provide you with the optimal dental care; my diagnosis of your needs will be the same, as I would make for a member of my own family. The following is an explanation of our financial policies. If you have any questions, please ask.

Appointments: Our goal is to provide quality dental care in a timely manner. In order to do so we have implemented an appointment/cancelation policy. The policy enables us to better utilize available appointments for our patients in need of dental care. Appointments are in high demand. Therefore, if it is necessary to cancel your scheduled appointment we require that you provide us with 24 hours notice. Your early cancelation will give another person the possibility to have access to timely dental care. If an appointment is missed without 24 hours notice being given, you will be subject to a $30 cancelation fee.

Financial Policies: Professional services are to be paid for on the day that they are rendered. If a service requires more than one visit (example: a crown), you may pay ½ of the fee at the start of treatment, with the balance to be paid in full once treatment is completed. For your convenience, we also accept Visa, MasterCard, American Express, & Discover. If extended payments are desired, this option is available through Wells Fargo Financial (6 months same as cash).
**ALL OVERDUE ACCOUNTS WILL RECEIVE A $15.00 MONTHLY LATE FEE THAT BECOMES THE RESPONSIBILITY OF THE ACCOUNT HOLDER TO PAY.*
If your account is placed for collections, the undersigned agrees to pay all attorney & collection fees.

Insurance: Our office policy is to bill your dental insurance carrier as a courtesy to you. **Although, you are responsible to pay your estimated portion on the day of service.** Once the carrier is billed, payment must be made in full within 60 days. If your insurance carrier does not remit payment in full with in 60 days, the balance is due in full by you. Since we are not a party to the agreement with your insurance carrier, it is not our policy to contact carriers to establish why they haven't paid differently than originally indicated.

*Please be advised that if you have treatment rendered that you would like to file with your medical insurance carrier, we *do not* file medical claims. We do not have access to medical diagnosis codes or treatment codes.

Philosophy: Our goal is to provide the best dental service possible. Proper dental care enhances your well-being; we want you to feel good about yourself and your oral health. Please feel free to ask any questions. We are honored to serve you, other members of your family, & your friends.

I have read and agreed to the above policy.

Signature (Patient, Parent, or Responsible Party): _____ Date: _____

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