



HEALTH HISTORY AND PATIENT INFORMATION

<p style="font-size: 2em; font-weight: bold; margin: 0;">ABOUT</p> <p style="text-align: center; margin: 0;">THE PATIENT</p> <p>Name _____</p> <p>Address _____</p> <p>_____</p> <p>Is patient living with both parents? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Age _____ Date of Birth _____</p> <p>Male _____ Female _____</p> <p>School _____ Grade _____</p> <p>Who may we thank for referring you to our office? _____</p>	<p style="font-size: 2em; font-weight: bold; margin: 0;">ABOUT</p> <p style="text-align: center; margin: 0;">PARENTS OR GUARDIAN</p> <p>Mother's Name/Guardian _____</p> <p>Address _____</p> <p>H. Phone _____ Beeper/Cell _____</p> <p>Occupation _____ W. Phone _____</p> <p>Father's Name _____</p> <p>Address _____</p> <p>H. Phone _____ Beeper/Cell _____</p> <p>Occupation _____ W. Phone _____</p> <p>Primary Household E-mail: _____</p>
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In case of an emergency, other than parent or guardian, who should we contact?

Name _____ Phone _____

Relationship to patient _____

For our records, please fill in the following insurance information. If you have dual insurance, the subscriber who's birthday is first in the calendar year, not their age, is considered the primary insured. Payment is requested at the time of the visit, regardless of insurance coverage, unless prior arrangements have been made.

Primary Insurance Company

Subscriber's Name _____

SS# _____ DOB _____

Employer _____

Insurance Co _____

Address _____

Phone # _____

Group # _____

Secondary Insurance Company

Subscriber's Name _____

SS# _____ DOB _____

Employer _____

Insurance Co _____

Address _____

Phone # _____

Group # _____

MEDICAL HISTORY

	<u>Yes</u>	<u>No</u>	<u>Staff Comments</u>
Physician's Name _____ Phone # _____			
Is your child being treated by a physician at this time? _____			
If yes, why? _____			
Has your child ever been a patient in a hospital? _____			
If yes, why? _____			
Is your child allergic to anything? (medication, food) _____			
If yes, what? _____			
Is your child taking any medications at this time? _____			
If yes, what? _____			

Has your child ever had any of the following medical conditions or problems? Please circle:

Heart Murmur Yes No

Convulsions/
Epilepsy Yes No

Asthma Yes No

Cancer Yes No

Diabetes Yes No

Rheumatic Fever Yes No

HIV+/AIDS Yes No

Hemophilia Yes No

Bleeding prob-
lems of any kind Yes No

Hearing Impair-
ment Yes No

Hyperactive Yes No

If there are any other medical conditions or problems, please list:

DENTAL HISTORY

	<u>Yes</u>	<u>No</u>	<u>Staff Comments</u>
Has your child ever been seen by a dentist before? _____			
Date _____ Name of Dentist _____			
Reason for this visit _____			
Has your child ever received fluoride in any form? _____			
If yes, what? _____			
Does your child suck a pacifier, thumb, or fingers? _____			
Are your child's teeth brushed once or more a day? _____			
Does an adult brush the child's teeth daily? _____			
Does your child swallow toothpaste during brushing? _____			
Does your child floss? _____			
Is your child still nursing? (bottle/breastfeeding) _____			
At what age did your child stop bottle/breastfeeding? _____			

Is there anything else that you think we should know about your child? _____

APPOINTMENT POLICY: PLEASE NOTIFY THIS OFFICE 24 HOURS PRIOR TO AN APPOINTMENT IF YOU MUST CANCEL IT. THIS OFFICE RESERVES THE RIGHT TO CHARGE A CANCELLATION FEE.

Kidzdent Children's Dental Care follows Federal and State law by complying with HIPPA standards. Our Notice of Privacy Practices took effect on April 15, 2003 and is available to you at your request.

I certify that I have read and understood the above. I understand that the information that I have given is correct to the best of my knowledge. I will not hold Kidzdent Children's Dental Care or any member of the staff responsible for any errors or omissions I may have made in the completion of this form. I also authorize the Doctors and dental staff to perform the necessary dental services my child may need.

Signature of parent/guardian _____ **Date** _____