Patient Health History Form

Patient Information

First Name

Middle Initial

Last Name

I prefer to be called (Nickname)

Birth date (MM-DD-YYYY)

Gender

Whom may we thank for referring you to our office?

Other family members seen by us

Parent / Guardian Information

Relationship to Patient (Circle) **Father** **Mother** **Legal Guardian** **Foster Parent**

Full Name

Street Address

City, State, Zip

Home Phone

Work Phone

Mobile Phone

Email Address

Social Security Number

Birth date

Employer

Single, Married or Divorced

Spouse's Name

Spouse's Social Security Number

Primary Dental Insurance

Insured's Name

Insured's Relationship to Patient

Insured's Birth Date

Insured's Social Security Number

Insured's Employer Name

Insurance Company Name

Insurance ID#

Group Number

Insurance Company Address

Insurance Phone Number

Secondary Dental Insurance

Insured's Name

Insured's Relationship to Patient

Insured's Birth Date

Insured's Social Security Number

Insured's Employer Name

Insurance Company Name

Insurance ID#

Group Number

Insurance Company Address

Insurance Phone Number

Emergency Information

Someone to notify in case of emergency not living with child

Relationship

Phone

Patient Medical History

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment child receives from our office. This information is kept strictly confidential.

Physician

Date of Last Visit

Physician Phone

Please circle Yes or No to which apply to child, and add any relevant comments.

Is the child currently being treated for any illness?	Yes	No	**Comment:**
Is child taking any medication?	Yes	No	**Comment:**
Is child allergic to any medication?	Yes	No	**Comment:**
Is the child allergic to anything else, such as certain foods?	Yes	No	**Comment:**
Does child have a history of any major illness?	Yes	No	**Comment:**
Has child ever received a general anesthetic or had any operations?	Yes	No	**Comment:**

Child's Name:

Has child ever been involved in a serious accident?	Yes	No	**Comment:**
Does the child have any inherited problems?	Yes	No	**Comment:**
Does the child have any speech difficulties?	Yes	No	**Comment:**

Please circle Yes or No for any conditions that child has had or currently has:

Abnormal bleeding/Hemophilia	Yes	No	**ADHD**	Yes	No
Anemia	Yes	No	**Arthritis**	Yes	No
Asthma or Hay fever	Yes	No	**Autism**	Yes	No
Bone Disorders	Yes	No	**Cerebral Palsy**	Yes	No
Congenital Heart Defect	Yes	No	**Diabetes**	Yes	No
Dizziness	Yes	No	**Down Syndrome**	Yes	No
Epilepsy	Yes	No	**Gastrointestinal Disorders**	Yes	No
Heart Murmur	Yes	No	**Heart Problems**	Yes	No
Hepatitis/Liver Problems	Yes	No	**Herpes**	Yes	No
High Blood Pressure	Yes	No	**HIV/Aids**	Yes	No
Kidney Problems	Yes	No	**Latex Allergy**	Yes	No
MRSA	Yes	No	**Nervous Disorders**	Yes	No
Pneumonia	Yes	No	**Prolonged Bleeding**	Yes	No
Radiation/Chemotherapy	Yes	No	**Rheumatic Fever**	Yes	No
Seizures	Yes	No	**Tuberculosis**	Yes	No
Tumor or Cancer	Yes	No			

Are there any medical conditions we have not discussed that you feel we should be aware of?

Patient Dental History

General Dentist **Date of Last Visit**

What concerns you most about child's teeth?

Please circle Yes or No to which apply to child, and add any relevant comments.

Is child presently in any dental pain?	Yes	No	**Comment:**
Has child ever experienced any unfavorable reaction to dentistry?	Yes	No	**Comment:**
Has child ever lost or chipped any teeth?	Yes	No	**Comment:**
Has child had any injuries to face, mouth or teeth?	Yes	No	**Comment:**
Is any part of child's mouth sensitive to temperature?	Yes	No	**Comment:**
Is any part of child's mouth sensitive to pressure?	Yes	No	**Comment:**
Does child have any type of thumb, pacifier or tongue habit?	Yes	No	**Comment:**
Is child a mouth breather?	Yes	No	**Comment:**
Has child ever seen an dentist?	Yes	No	**If yes, who?**
Do child's teeth or jaws ever feel uncomfortable when child awakes in the morning?	Yes	No	**Comment:**
Are you aware of child's jaws clicking or popping?	Yes	No	**Comment:**
Are you aware of child clenching teeth during the day?	Yes	No	**Comment:**

Child's Name:

Has child ever been told that child grinds their teeth?	Yes	No	**Comment:**		
Does child have 'tension' headaches?	Yes	No	**Comment:**		
Has child ever experienced chronic ringing in child's ears?	Yes	No	**Comment:**		
At what age did the child stop bottle feeding?			**At what age did the child stop breast feeding?**		
Does the child take fluoride supplements?	Yes	No	**Does the child use fluoride toothpaste?**	Yes	No
What type of water does child drink (City, Well, Bottled, Filtered)?					

HIPAA Acknowledgement and Signature

By signing your name, you are agreeing to the following:

I acknowledge that a copy of Kidspace Pediatric Dentistry's "HIPAA Notice of Privacy Practices" was made available to me.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I understand that missing 3 appointments without 24 hour notice may result in dismissal from dental care at Kidspace Pediatric Dentistry.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

Signature **Date**