Welcome

We are pleased to welcome you and your child to our practice. Please fill out this form as completely as you can. We look forward to working with you in maintaining your child's dental health.

Smile-Savers Pediatric Dentistry, PC
www.smilesaverspedo.com

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Patient's Health History Form

Please PRINT all information CLEARLY.

1. About Your Child

Child's Name _____
Last First MI

Nickname _____ Male ☐ Female ☐

Child's Birthdate _____/_____/_____ Child's Age _____

Child's Home # (_____)_____

Child's Home Address: _____

_____
City State Zip

2. Reason for this visit?

_____

_____

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL # _____

4. Father's Information

Name _____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL # _____

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

6. How did you hear about us?

_____

_____

7. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

_____
City State Zip

8. 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 _____

9. 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 _____

over →

10. Dental History

Is this your child's first visit to the dentist? Yes No

If not, how long since the last dental visit? _____

Were any x-rays taken at the last dental visit? Yes No

Previous injuries to the teeth, face, or mouth? Yes No

Are you aware of any current dental problems, which you expect will require treatment? Yes No

If yes, please explain _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting

Y N Nail Biting

Y N Nursing / Bottle / Pacifier Habits

Y N Tongue Thrusting

Y N Thumb / Finger Sucking

Y N Clenching / Grinding

Y N Other _____

Has your child had an unfavorable experience in a previous dental/medical office? Yes No

If yes, please explain _____

_____

Does the child use bottled water? Yes No

Is fluoride in the child's water? Yes No

Is the child taking fluoride supplements? Yes No

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

Floss his/her teeth daily? Yes No

Does an adult help the child to brush/floss? Yes No

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

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

11. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N ADD/ADHD

Y N Allergies to any Drugs

Y N Allergies to Latex Products

Y N Any Hospital Stays/Operations

Y N Any Operations

Y N Asthma/Bronchitis

Y N Autism/PDD

Y N Cancer

Y N Congenital Birth Defects

Y N Convulsions/Epilepsy

Y N Developmental Delay/Learning Disabilities

Y N Diabetes

Y N Handicaps/Physical Disabilities

Y N Hearing Impairment

Y N Heart Disease/Murmur/MVP

Y N Hemophilia/Blood Disorders

Y N Hepatitis

Y N HIV + / AIDS

Y N Kidney/Liver Conditions

Y N Premature/Low Birth weight

Y N Rheumatic/Scarlet Fever

Y N Tuberculosis

Please explain items marked (Y) above:

_____

_____

Please list all drugs the child is currently taking (prescription/OTC):

_____

_____

Please list all drugs the child is allergic to _____

_____

Immunizations up-to-date? Yes No

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

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform the staff of ***Smile-Savers Pediatric Dentistry*** of any changes in my child's medical status. I give the doctors permission to use such measure as deemed necessary in their professional judgment to render a diagnosis and perform the necessary dental services for my child.

_____ _____ _____

Signature Date Relationship to Patient