Atlantic Coast Dentistry for Children

Patient Health History

Patient ID: _____

Today's Date: _____

Your Child:

Child's Name: _____

Child's Home Address Sex: ☐ M ☐ F

Street: _____

City: _____ State: _____

Zip: _____

Phone: _____

SS/SIN: _____

School: _____

Nickname:

Birthday:

_____ mm

_____ dd

_____ yyyy

Welcome to our Practice!

We strive to make your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will keep their smile beautiful for their liftime.

Who Makes the Appointments:

Name: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Best Time to Call: _____

(days & time) _____

Parent's Marital Status: (check one)

Single ☐ Married ☐

Widowed ☐ Separated ☐

Divorced ☐

☐ Mother ☐ Stepmother ☐ Guardian:

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

SS/SIN: _____

Employer: _____

Occupation: _____

DL#: _____

☐ Father ☐ Stepfather ☐ Guardian:

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

SS/SIN: _____

Employer: _____

Occupation: _____

DL#: _____

Responsible Party:

Name: _____

Relationship: _____

Address: _____

SS/SIN: _____

DL#: _____

Email: _____

Phone: _____

Primary Dental Insurance:

Insured's Name: _____

Relationship: _____

Birthdate: _____ Group No: _____

SS/SIN: _____ Emp. No: _____

Employer: _____ Deductible: _____

Date Employed: _____ Amount Already Used: _____

Occupation: _____ Max Annual Benefit: _____

Insurance Company: _____

Insurance Co. Address: _____

Orthodontic Coverage: Yes / No

Additional Insurance:

Insured's Name: _____ Relationship: _____

Birthdate: _____ Group No: _____

SS/SIN: _____ Emp. No: _____

Employer: _____ Deductible: _____

Date Employed: _____ Amount Already Used: _____

Occupation: _____ Max Annual Benefit: _____

Insurance Company: _____

Insurance Co. Address: _____

Orthodontic Coverage: Yes / No

Your child's overall heath as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Patient Health History

Patient ID: _____

Today's Date: _____

Health History:

Has your child had difficulty with previous visits?

_____

Does your child have history of allergies to any substances (latex, environmental, etc)?

_____

Has your child ever had any of the following?

Acid Reflux: Yes / No
Allergies: Yes / No
Anemia: Yes / No
Asthma: Yes / No
Blood Transfusion: Yes / No
Cancer: Yes / No
Hearing Impairment: Yes / No
Heart Problems: Yes / No
Hemophilia/Abnormal Bleeding: Yes / No
Hepatitis: Yes / No
HIV/AIDS: Yes / No
Persistent Cough: Yes / No
Rheumatic Fever: Yes / No
Tuberculosis: Yes / No

Please explain any medical problems that your child has:

_____

_____

Child's Habits:

How often does your child brush: _____

How often does your child floss: _____

Date of last dental visit: _____

Previous dentist: _____

Child's Physician: _____

Phone Number: _____

Child's Birthdate: _____

Is your child's water fluoridated: Yes / No
Does your child take fluoride supplements: Yes / No
Does your child suck their thumb/finger: Yes / No
Does your child suck/bite lips: Yes / No
Does your child bite/chew nails: Yes / No
Does your child chew hard objects like pencils: Yes / No
Does your child grind their teeth: Yes / No
Does your child clench their jaw: Yes / No

Authorization and Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Parent/Guardian if minor: _____ **Date:** _____

for office use _____

Dentist's Review: _____

_____

_____

_____

_____

Doctor Signature: _____ **Date:** _____

History Update: _____

_____

Signature: _____ **Date:** _____

History Update: _____

_____

Signature: _____ **Date:** _____