Children History Form

WELCOME!

Proper dental hygiene begins at an early age.
Please take a few minutes to complete the following information so we can better care for your child's dental needs.

Patient and Family Information

Child's Name_____
Birth date____/____/_____
Male ☐ Female ☐ Home Phone_____

Home Address_____
City Sate Zip
School_____
Grade_____
Responsible Party_____
Relationship to Child_____
Name of Mother/Guardian_____
Birth date___/___/_____
Social Security #_____Home Phone_____
Address_____
City State Zip
Employer_____
Business Phone_____
Cell Phone_____
E-mail_____

Name of Father/Guardian_____
Birth date____/___/_____
Social Security #_____Home Phone_____
Address_____
City State Zip
Employer_____
Business Phone_____
Cell Phone_____
E-mail_____

Child's Dental History

Former Dentist_____
Office Phone_____
Date of last dental visit_____
How often does your child brush?_____
How often does your child floss?_____

Please circle all that apply to your child:

Thumb/Finger Sucking Fingernail Biting
Lip or Cheek Biting Grinding Teeth
Jaw Difficulty: Clicking and or Pain

Child's Health History

Please circle all that apply to your child:

Allergies Anemia Asthma
Cancer Diabetes Epilepsy
HIV/AIDS Heart Murmur
Hepatitis-Type_____ Rheumatic Fever
Scarlet Fever Tonsillitis Tuberculosis
Other:_____

INSURANCE

Primary Insurance

Dental Coverage? YES NO
Insurance Co. Name:_____
Insurance Co. Address:_____
City State zip
Ins. Co. Phone #:(___)_____
Group # (plan,local or Policy#):_____
Insured's Name_____
Relation_____
Insured's Birth date:____/____/_____
Insured's ID#:_____
Insured's Employer:_____

Secondary Insurance

Dental Coverage? YES NO
Insurance Co. Name:_____
Insurance Co. Address:_____
City State zip
Ins. Co. Phone #:(___)_____
Group # (plan,local or Policy#):_____
Insured's Name_____
Relation_____
Insured's Birth date:____/____/_____
Insured's ID#:_____
Insured's Employer:_____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to_____for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize the above doctor and or any provider or supplier of services in this office to release the information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party:

X_____Date_____

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit?
If yes, please explain._____

X_____
Patient Signature Date
X_____
Dentist Signature Date

Has there been any change in your health status since your last visit?
If yes, please explain._____

X_____
Patient Signature Date
X_____
Dentist Signature Date