Health History 18 and Under

Patient Name: _____Date: _____
Referred By: _____

Dentist's Name: _____
Date of last dental visit: _____What service was performed: _____
Has the child ever had a serious/difficult problem associated with previous dental work? __ Y/N
Does the child brush their teeth daily? _____ Y/N
What is the child's attitude toward dentistry? _____
Has your child ever been prescribed Fosamax or any other bisphosphonate? _____ Y/N
If yes when? _____
Has your child been evaluated or had orthodontic treatment before? _____ Y/N
Have there been any injuries to the face, mouth, teeth or chin? _____ Y/N
List any musical instruments played: _____
Have adenoids or tonsils been removed? _____ Y/N
Has your child been informed of any missing or extra permanent teeth? _____ Y/N
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? _____ Y/N
Does your child brush his/her teeth daily? _____ Y/N
Floss his/her teeth daily?_____ Y/N

Physician's Name: _____
Date of last visit? _____Is your child currently under the care of a physician? Y/N
Has puberty begun?_____ Y/N
Has menstruation begun? (Girls) _____ Y/N
Please describe your child current physical health: Good Fair Poor
Please list all drugs your child is currently taking:_____
_____
Please list all drugs/things your child is allergic to: _____
_____

Has your child ever had any of the following medical problems?

Abnormal Bleeding_____ Y/N
ADD/ADHD _____ Y/N
Allergies to any Drugs _____ Y/N
Allergies to Latex/Metals _____ Y/N
Allergic to Plastic _____ Y/N
Any Hospital Stays _____ Y/N
Any Operations _____ Y/N
Artificial Bones/Joints/Valves _____ Y/N
Autism /Asperger Syndrome_____ Y/N
Asthma _____ Y/N
Cancer _____ Y/N
Tuberculosis (TB) _____ Y/N
Congenital Heart Defect _____ Y/N
Convulsions/Epilepsy _____ Y/N
Diabetes_____ Y/N
Handicaps/Disabilities _____ Y/N
Hearing Impairment _____ Y/N
Heart Murmur _____ Y/N
Hemophilia _____ Y/N
Hepatitis _____ Y/N
HIV+/AIDS_____ Y/N
Kidney/Liver Problems_____ Y/N
Lupus_____ Y/N
Rheumatic/Scarlet Fever _____ Y/N

Please discuss any medical problems that your child has had:_____
_____
_____

Has your child ever experienced any of the following?

Clenching/Grinding Teeth _____ Y/N		Nursing Bottle Habits _____ Y/N	
Lip Sucking/Biting _____ Y/N		Speech Problems_____ Y/N	
Mouth Breather_____ Y/N		Thumb/Finger Sucking _____ Y/N	
Nail Biting_____ Y/N		Tongue Thrust _____ Y/N	

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian Date

I understand that this office will file insurance with any company except Sooner Care, Medicaid and Medicare. I understand that I am ultimately responsible for payment of any services rendered including co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize release of any information relating to this claim. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature of Parent or Guardian Date

This office reserves the right to verify the credit status of potential patients and or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office use the services of one or more credit reporting services.

_____ _____
Signature of Parent or Guardian Date

The Parent or Guardian who accompanies the child is responsible for payment.
Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.