clay·dental
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HEALTH HISTORY FORM

FOR YOUR CONVENIENCE:

Print this form, complete all information, and bring it with you on your first visit to our office.
The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child:

Child's Name:

_____
Last First Middle
Nickname: _____
Male Female

Siblings that we treat:

_____
Child's Birthdate_____/_____/_____
Child's Age _____
School name_____
Grade_____
Child's Phone #(_____)_____
SS#_____
Child's Home Address:_____
_____
City_____State_____
Zip_____
E-mail:_____

2. Mother's Information

Name_____
Mother Stepmother Guardian
Birthdate _____/_____/_____
Employer _____
Work # (____)_____ Ext. _____
Home # (____)_____
Cellular Phone # (____)_____
SS # _____ DL#_____

3. Father's Information:

Name _____
Father Stepfather Guardian
Birthdate _____/_____/_____
Employer _____
Work #: (_____)_____ Ext. _____
home # (_____)_____
Cellular Phone # (_____)_____
SS # _____ DL#_____

4. Who may we thank for referring you to our office?

_____

5. ¿Who is Accompanying the Child Today?

Name: _____
Relationship:_____
Do you have legal custody of this child? Yes No

6. Person Responsible for Account

Name: _____
Relationship:_____
Billing Address:_____
City_____State_____
Zip_____
Work # (____)_____ Ext. _____
Home # (____)_____
Celular Phone # (____)_____
E-mail:_____

7. 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:
_____

8. 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:
_____

9. Dental History

Is this your child's first visit to the dentist?

_____

If not, how long since the last visit to the dentist?

_____

Were any x-rays taken at previous dental visits?

_____

Have there been any injuries to the teeth, face or mouth?

_____

_____

If yes, please explain:

_____

_____

Why did you bring the child to the dentist today?

_____

_____

Does the child have any of the following habits?

Yes No Lip Sucking / Biting
Yes No Nail Biting
Yes No Nursing / Bottle Habits
Yes No Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work?

Yes No

If yes, please explain:

_____

_____

Is the child's water fluoridated?
Yes No
Is the child taking fluoride supplements?
Yes No
Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)?
Yes No
Does the child brush his/her teeth daily?
Yes No
Does the child floss his/her teeth daily?
Yes No

10. Medical History

Has the child had any of the following conditions?

Yes No Abnormal Bleeding
Yes No Allergies to any Drugs
Yes No Any Hospital Stays
Yes No Any Operations
Yes No Asthma
Yes No Cancer
Yes No Congenital Birth Defects
Yes No Convulsions/Epilepsy
Yes No Pregnancy
Yes No Tuberculosis
Yes No Handicaps/Disabilities
Yes No Hearing Impairment
Yes No Heart Disease/Murmur
Yes No Hemophilia/Blood Disorders
Yes No Hepatitis
Yes No HIV + / AIDS
Yes No Kidney/Liver Conditions
Yes No Rheumatic/Scarlet Fever
Yes No Allergies to Latex Product
Yes No Diabetes

Please discuss any serious medical conditions the child has had_____

_____

Please list all drugs the child is currently taking _____

_____

_____

Please list all drugs the child is allergic to:

_____

_____

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

11. 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 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 Relationship to Patient

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

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

_____

_____