pediatric

Dentistry, Ltd.

3142 49th Street South
Fargo, North Dakota 58104
phone: (701) 293-6999 *fax:* (701) 235-2297

Health History Form

1. Tell Us About Your Child

Child's Name ____________________
Last First MI

Nickname ____________ ☐ Male ☐ Female

Siblings that we treat ____________

Child's Birth date ____/____/____ Child's Age ________

Child's Home # (________) ____________

Hobbies/Interests ____________

Child's Home Address: ____________

City State Zip

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

____

____

3. Parent Information

Name ____________

Mother Father Other Birth date ____/____/____

Marital Status: M S D

Employer ____________

Work # (________) ____________ Ext. ______

Home # (________) ____________

Cellular Phone # (________) ____________

SS # ____________

4. Parent Information

Name ____________

Father Mother Other Birth date ____/____/____

Marital Status: M S D

Employer ____________

Work # (________) ____________ Ext. ______

Home # (________) ____________

Cellular Phone # (________) ____________

SS # ____________

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

Home # (________) ____________

Work # (________) ____________ Ext. ______

Cellular # (________) ____________

Email ____________

7. Primary Dental Insurance

Insurance Co. Name ____________

Insurance Co. Address ____________

____

Insurance Co. Phone # (________) ____________

Group # ____________ ID # ____________

Policy Owner's Name ____________

Relationship to Patient ____________

Policy Owner's Birth Date ____/____/____

Policy Owner's Employer ____________

8. Secondary Dental Insurance

Insurance Co. Name ____________

Insurance Co. Address ____________

____

Insurance Co. Phone # (________) ____________

Group # ____________ ID # ____________

Policy Owner's Name ____________

Relationship to Patient ____________

Policy Owner's Birth Date ____/____/____

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?

Y N Lip Sucking / Biting   Y N Nail Biting

Y N Nursing / Bottle Habits   Y N 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

Floss his/her teeth daily?   Yes   No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding   Y N Autism

Y N Allergies to any Drugs   Y N Hearing Impairment

Y N Any Hospital Stays   Y N Heart Disease/Murmur

Y N Any Operations   Y N Hemophilia/Blood Disorders

Y N Asthma   Y N Hepatitis

Y N Cancer   Y N HIV / AIDS

Y N Congenital Birth Defects   Y N Kidney/Liver Conditions

Y N Convulsions/Epilepsy   Y N Rheumatic/Scarlet Fever

Y N Diabetes   Y N Allergies to Latex Product

Y N Tuberculosis   Y N Hearing/Speech Problems

Y N Emotional Problems   Y N Behavior Problems/ADHD

Please discuss any serious medical conditions the child has had

____

____

Please list all drugs the child is currently taking ____________

____

Please list all drugs/food the child is allergic to ____________

____

Child's Physician: ____________

Clinic: ____________

Phone: ____________ Fax: ____________

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

Initials ____________ Date ____________ Initials ____________ Date ____________

Initials ____________ Date ____________ Initials ____________ Date ____________

Initials ____________ Date ____________ Initials ____________ Date ____________

Initials ____________ Date ____________ Initials ____________ Date ____________

Doctor's Comments ____________

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