



Medical History Form

MEDICAL HISTORY

Does the **Patient** have any history of the following?

Heart Problems or murmur	YES	NO	(?)
Rheumatic fever	YES	NO	(?)
Bleeding or clotting problems	YES	NO	(?)
Sickle cell anemia or trait	YES	NO	(?)
Cleft lip or palate	YES	NO	(?)
Birth defects or genetic disorders	YES	NO	(?)
Epilepsy or seizures	YES	NO	(?)
Mental retardation	YES	NO	(?)
Autism/Developmental Delay	YES	NO	(?)
Growth problems	YES	NO	(?)
Cerebral palsy	YES	NO	(?)
Ear or hearing problems	YES	NO	(?)
Speech difficulties	YES	NO	(?)
Vision problems	YES	NO	(?)
Asthma or wheezing	YES	NO	(?)
Allergies (hay fever, latex sensitivity, etc.)	YES	NO	(?)
Feeding or eating disorders	YES	NO	(?)
Hepatitis or liver disease	YES	NO	(?)
Diabetes	YES	NO	(?)
Tuberculosis	YES	NO	(?)
Kidney problems	YES	NO	(?)
Bone or joint problems	YES	NO	(?)
Drug or alcohol use	YES	NO	(?)
Smoking or use of snuff or smokeless tobacco	YES	NO	(?)
Sexually transmitted or venereal disease (VD)	YES	NO	(?)
AIDS or AIDS-related complex	YES	NO	(?)
Cancer	YES	NO	(?)
Relation Therapy	YES	NO	(?)
Other medical problems (specify) _____	YES	NO	(?)
Name of patient's physician _____			
Date of last visit _____			
Address _____			
Phone # _____			
Is the patient currently under the care of a physician?	YES	NO	(?)
If yes, for what condition? _____			
Has your medical doctor instructed you to have your child take Penicillin before each dental visit	YES	NO	(?)
Is the patient currently taking any medications?	YES	NO	(?)
If yes, list _____			
for what condition? _____			
Has the patient had any allergic or unfavorable reaction any medications?	YES	NO	(?)
To what? _____ Reaction _____			
Have you or your child had any complications due to anesthesia?	YES	NO	(?)
Has the patient ever been hospitalized?	YES	NO	(?)
Age _____ Reason _____			
Are the patient's immunizations up-to-date?	YES	NO	(?)
Is there any additional medical information about the patient not reported above?	YES	NO	(?)
If yes, describe _____			

DENTAL HISTORY

Why is the patient seeking dental care? _____ YES NO (?)
 Is this the patient's first visit to a dentist? YES NO (?)
 If no, give date of last visit _____

Has the patient had any of the following dental problems?
 Injuries to mouth or teeth YES NO (?)
 Toothaches/pain YES NO (?)
 Abscesses (gum boils) YES NO (?)
 Other (specify) _____

Does the patient have any of the following habits?
 Finger/thumb/pacifier sucking YES NO (?)
 Tooth grinding or clenching YES NO (?)
 Other (specify) _____

At what age was bottle or breast feeding stopped? _____

What is the source of the patient's current drinking water supply?
 _____ City _____ Home well _____ Bottled _____ Don't know

Is this water fluoridated? YES NO (?)
 Does patient receive fluoride tablets, drops or vitamins with fluoride? YES NO (?)
 Who is responsible for brushing the patient's teeth? _____

Is there any additional dental information we should know? YES NO (?)
 If yes, describe _____

SOCIAL & BEHAVIORAL HISTORY

Do you think the patient will cooperate for dental treatment? YES NO (?)
 Has the patient had a bad or fearful dental or medical experience? YES NO (?)
 Which of the following best describes the patient?
 _____ Advanced in the learning process _____ Progressing normally _____ Slow learner

Does the patient have any history of emotional or behavioral problems? YES NO (?)
 If yes, describe _____

Are there any cultural, religious or ethnic concerns that could affect the care of your child? YES NO (?)
 If yes, describe _____

Names and ages of other children in the family _____

Is there any additional information we should know? YES NO (?)
 If yes, comment _____

In case of hospitalization, trauma or emergency, please provide the name of your medical Insurance provider/company _____

To the best of my knowledge the above information is correct.

Signature of person completing form _____ Date _____ Relationship to patient _____



Patient Name: _____ Preferred Name: _____

Birth Date: _____ Age: _____ Gender: _____

RESPONSIBLE PARTY

The parent(s) who bring the child(ren) to their initial visit is the responsible party for the account. In the case of divorce or separation the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child, irregardless of who carries the insurance, is the parent responsible for those subsequent charges, if the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other.

Who is responsible for the account? (if married, both parents are responsible)

Parent/Guardian #1: _____

Parent/Guardian #2: _____

Single or Married?: _____

Single or Married?: _____

Relation to Patient: _____

Relation to Patient: _____

Street Address: _____

Street Address: _____

City/State/Zip: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ SS#: _____

Birth Date: _____ SS#: _____

E-mail: _____

E-mail: _____

How did you hear about our office? (Circle) Internet Phonebook Friend Flyer Dentist

Please list name of referring Dentist or friend: _____

How do you prefer to be contacted: (Circle) E-mail Home Phone Cell Phone Mail

DENTAL INSURANCE

PRIMARY INSURANCE

Name of Insured: _____

Address: _____

City/State/Zip: _____

Phone: _____

Birth Date: _____ SS#: _____

Employer: _____

Occupation: _____

Insurance Company: _____

Address: _____

City/State/Zip: _____

Group #: _____

Insurance ID#: _____

SECONDARY INSURANCE

Name of Insured: _____

Address: _____

City/State/Zip: _____

Phone: _____

Birth Date: _____ SS#: _____

Employer: _____

Occupation: _____

Insurance Company: _____

Address: _____

City/State/Zip: _____

Group #: _____

Insurance ID#: _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors 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 the payment of all services rendered on my behalf of my dependants.

Signature: _____ Date: _____ Payment for services and estimated insurance co-payments are due at time of service unless other arrangements have been approved in writing. It is also my understanding that 2 (two) consecutive broken appointments without explanation will lead to the dismissal of my family as patients.

Signature: _____ Date: _____