

## Health History and Patient Information

## Patient Information

Child's First / Last Name	Preferred name	Birth date	A	age Mal	le/Female	
Social Security # School		Grade	Wei	ight H	eight	
Mailing address		City	Zi	Zip State		
( )						
Home Phone #		Reason for today	's visit			
*Who referred you to our office	? (We wish to the	hank them)				
	Medical H	istory				
(	)	•				
Child's Physician	Phone #			Date last see	n (Mo/Yr)	
				Yes	No	
Is your child currently under the care of If yes, for what?	. ·	•	ems?	<del></del>		
Is your child currently taking any medi If yes, what?						
Is your child allergic to any food or me If yes, what?						
Has your child ever been hospitalized of If yes, for what?						
Has your child ever received general at If yes, when? Any ut						
Has your child been treated for	any of the fo	llowing medical	condition	ons:		
Y N Abnormal Bleeding	Y N Allergy	_	Y N	Anemia		
Y N Arthritis	Y N Asthma	_	YN			
Y N Brain injury	Y N Bronchit			Convulsions/S		
Y N Cancer	Y N Cerebral	•		Cleft lip/palat		
Y N Developmental delay	Y N Diabetes			Eye Problems	S	
Y N Fainting	Y N Hearing Y N Heart dis			Hepatitis		
Y N Hemophilia Y N HIV/AIDS	Y N Mental I			N Heart murmur		
Y N Liver disease	Y N Respirate			N Kidney disease N Rheumatic fever		
Y N Sinus problems/snoring at night	Y N Skin rash			Scoliosis	2001	
Y N Other						
Please rate your child's current physica	al health: Go	ood Fair		Poor		
Pharmacy		Phone #				

## Dental History

Mother's full name:  Mailing address: (if different)  Occupation:  Employer:  Home #:  E-mail:  Siblings (names and ages):  Has any member of your family been a patient of this office before? Y N Name:  *In case of an emergency, who should we contact?  Name:  Relationship:  Address:  Phone # 1:  Phone # 2:  Insurance and financial responsibility  Is your child covered by a dental insurance plan? Y N Name of Insurance:  Name of parent insured:  Employed by:  SS#:  Insured DOB:  Group or policy #:  Insurance company phone #:  Person responsible for child's account:  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 hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes. I understand that payment is expected for service rendered at the time of service. I also understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.	Patient Name	Date of	f Birth			
If yes, please explain:  Has your child experienced any unfavorable reaction to medical or dental care? Y N  If yes, please explain:  How do you think your child will react to the demtist?  How often does your child brush?  Je it supervised?  By Whom?  Does your child floss? Y N Is your child receiving fluoride in water or vitamins? Y N  Does your child have any of the following habits:  Y N Thumb/linger sucking Y N Pacifier sucking Y N Bottle/breast feeding (>1 year old)  Y N Sippy cup Y N Nail biting Y N Lip biting/sucking  Y N Mouth breathing Y N Grinding/clenching Y N Other  Family information  Father's full name:  SS#  DL#  Mailing address:  Occupation:  Home #:  Work #:  Cell #:  Employer:  Home #:  Work #:  Cell #:  Email:  Mother's full name:  SS#:  DL#  Mailing address: (if different)  Occupation:  Home #:  Work #:  Cell #:  Email:  SShibings (names and ages):  Has any member of your family been a patient of this office before? Y N Name:  "In case of an emergency, who should we contact?  Name:  Name:  Name:  Phone # 2:  Insurance and financial responsibility  Is your child covered by a dental insurance plan? Y N Name of Insurance:  SS#:  Insurance company phone #:  Person responsibile for child's account:  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 hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child's reteit for diagnostic purposes. I understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.						
How do you think your child will react to the dentist?  How often does your child brush?  Does your child floss? Y N Is your child receiving fluoride in water or vitamins? Y N Does your child have any of the following habits: Y N Thumb/finger sucking Y N Pacifier sucking Y N Bottle/breast feeding (>1 year old) Y N Sippy cup Y N Nail bitting Y N Lip biting/sucking Y N Mouth breathing Y N Grinding/clenching Y N Other  Family information  Father's full name:  S\$#				N		
How often does your child brush?						N
Does your child floss? Y N Is your child receiving fluoride in water or vitamins? Y N Does your child have any of the following habits: Y N Thumb/finger sucking Y N Pacifier sucking Y N Bottle/breast feeding (>1 year old) Y N Sippy cup Y N Nail biting Y N Lip biting/sucking Y N Mouth breathing Y N Grinding/clenching Y N Other  Family information  Father's full name: SS# DL#  Mailing address: Occupation: Employer: Home #: Cell #: E-Mail: Work #: Cell #: E-Mail: Mother's full name: SS#: DL# Mailing address (if different) Occupation: Employer: Home #: Cell #: E-mail: Siblings (names and ages): Has any member of your family been a patient of this office before? Y N Name: Siblings (names and ages): Has any member of your family been a patient of this office before? Y N Name: Mame: Address: Phone # 1: Phone # 2: Employed by: SS#: Insurance and financial responsibility  Is your child covered by a dental insurance plan? Y N Name of Insurance: Employed by: SS#: Insurance company phone #: Person responsible for child's account: Insurance company phone #: Person responsible for child's account: Insurance company phone #: Person responsible for child's account: Insurance company phone #: Person responsibility to inform this office of any changes in my child's medical status. I hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes. I understand that payment is expected for service rendered at the time of service. I also understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.	How do you think your child will re	eact to the dentist?				
Father's full name:	Does your child floss? Y N  Does your child have any of Y N Thumb/finger sucking	Is your child rece the following hab Y N Pacifier sucl	iving fluoride <b>its:</b> king Y M	in water or v  N Bottle/bre	ritamins?	Y N (>1 year old)
Mailing address:		Family info	ormation			
Home #:	Mailing address:					
E-Mail:    Mother's full name:						
Mother's full name:  Mailing address: (if different)  Occupation:  Home #:  E-mail:  Siblings (names and ages):  Has any member of your family been a patient of this office before? Y N Name:  *In case of an emergency, who should we contact?  Name:  Relationship:  Address:  Phone # 1:  Phone # 2:   Insurance and financial responsibility  Is your child covered by a dental insurance plan? Y N Name of Insurance:  Name of parent insured:  Employed by:  SS#:  Insured DOB:  Group or policy #:  Insurance company phone #:  Person responsible for child's account:  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 hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes. I understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.	F 3.6 ''					
Mailing address: (if different)  Occupation:			SS#:		DL#	
Occupation:	Mailing address: (if different)					
E-mail: Siblings (names and ages): Has any member of your family been a patient of this office before? Y N Name:  *In case of an emergency, who should we contact? Name: Relationship: Address: Phone # 1: Phone # 2:  Insurance and financial responsibility  Is your child covered by a dental insurance plan? Y N Name of Insurance: Name of parent insured: Employed by: SS#: Insured DOB: Group or policy #: Insurance company phone #: Person responsible for child's account:  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 hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes. I understand that payment is expected for service rendered at the time of service. I also understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.	Occupation:	Empl	loyer:			
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*In case of an emergency, who should we contact?  Name:	E 11					
*In case of an emergency, who should we contact?  Name:			Fine before?	V N Nor		
Name:	has any member of your family bee	en a patient of this of	nce before?	I IN INAI	ne	
Name:	*In case of an emergency, who sh	ould we contact?				
Address: Phone # 1:  Insurance and financial responsibility  Is your child covered by a dental insurance plan? Y N Name of Insurance: Name of parent insured: SS#: Insured DOB: Person responsible for child's account:  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 hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes. I understand that payment is expected for service rendered at the time of service. I also understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.			lationship:			
Insurance and financial responsibility  Is your child covered by a dental insurance plan? Y N Name of Insurance:    Syman			=			
Is your child covered by a dental insurance plan? Y N Name of Insurance:  Name of parent insured:  SS#:  Insured DOB:  Person responsible for child's account:  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 hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes. I understand that payment is expected for service rendered at the time of service. I also understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.	Phone # 1:	Phone	# 2:			
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Name of parent insured:  SS#:  Insured DOB:  Person responsible for child's account:  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 hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes. I understand that payment is expected for service rendered at the time of service. I also understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.						
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electronically. Finally, I understand my privacy rights and how my information can be used.		• •	•			
used.						
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Signature: Date: Relationship to child: Date:		Relationshi	ip to child:		Date:	