PATIENT HEALTH HISTORY FORM

WILD ABOUT Smiles!
pediatric dentistry & orthodontics

Thank you for giving us the privilege of serving your child's dental health needs. We are committed to providing the best possible care. Complete and thorough answers to the following questions will help make this possible. Thanks again for your cooperation.

PLEASE USE BLUE OR BLACK INK TO COMPLETE THIS FORM.

PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____
Birth Date: _____ Age: ____ Gender: ❑M ❑F Child's SS #: _____
Home Phone #: _____ Mom/Dad Cell Phone #: _____ Parent Email Address: _____
Home Address: _____ City, State, ZIP: _____
Physician or Pediatrician: _____ Physician Phone #: _____
Whom may we thank for referring you to our office? _____ Child's Interests: _____
School: _____ Grade: _____ _____
Name(s) and age(s) of sibling(s): _____

PARENT/GUARDIAN INFORMATION

Father/Guardian Name: _____ DOB: _____ Driver's License #: _____ SS #: _____
Home Phone #: _____ Address: _____ City, State, ZIP: _____
Employer: _____ Work Phone #: _____ Cell Phone #: _____
Mother/Guardian Name: _____ DOB: _____ Driver's License #: _____ SS #: _____
Home Phone #: _____ Address: _____ City, State, ZIP: _____
Employer: _____ Work Phone #: _____ Cell Phone #: _____
Do the father, mother, and child all live together? ❑ Yes ❑ No If no, please explain: _____
Nearest living relative other than parent/guardian: _____ Phone #: _____
Relation: _____ Address: _____ Work Phone #: _____
Person responsible for account: _____

Insurance: Name of Insured: _____ ID #: _____ Group #: _____
Name of Insurance: _____
Mailing Address for Insurance Co.: _____

MEDICAL INFORMATION: PLEASE ANSWER EVERY QUESTION

	Yes	No		
A.	❑	❑	Has your child ever been to the emergency room? Explain: _____	Date: _____
B.	❑	❑	Has your child ever been hospitalized? Explain: _____	Date: _____
C.	❑	❑	Is your child now under the care of a physician? If so, why? _____	
D.	❑	❑	Is your child taking any medications? If yes, which ones? _____	
E.	❑	❑	Is your child allergic to anything? If yes, to what? _____	
F.	❑	❑	Has your child ever had a reaction to penicillin or any other drugs? If yes, what drugs? _____	

Does your child now have or has he/she ever had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Rheumatic fever	❑	❑	Tuberculosis	❑	❑	Cerebral palsy	❑	❑	AIDS
❑	❑	Heart disease	❑	❑	Anemia	❑	❑	Hepatitis	❑	❑	Eye problems
❑	❑	Heart murmur	❑	❑	Thyroid disease	❑	❑	Diabetes	❑	❑	Hearing problems
❑	❑	Liver disease	❑	❑	Blood transfusion	❑	❑	Epilepsy	❑	❑	Cleft lip/palate
❑	❑	Kidney disease	❑	❑	Sickle-cell disease or trait	❑	❑	Birth defects	❑	❑	Speech problems
❑	❑	Bladder disease	❑	❑	Blood disorders	❑	❑	Cancer	❑	❑	Other Special Needs:
❑	❑	Respiratory disease	❑	❑	Autism	❑	❑	Asthma			_____

DENTAL HISTORY

Purpose of this visit:

Is today your child's first visit to the dentist? ❑ Yes ❑ No If no, give date of last visit: _____

Have your child's teeth ever been X-rayed? ❑ Yes ❑ No If yes, by whom? _____

Has your child ever sucked on his/her: ❑ fingers ❑ thumb ❑ or pacifier? ❑ Yes ❑ No Is this habit still active? ❑ Yes ❑ No

Does your child have a history of taking a bottle, nursing, and/or sippy cup after one (1) year of age? ❑ Yes ❑ No

Which of the following describes your home drinking water? ❑ City water ❑ Well water ❑ Filtration system ❑ County water

Does your child brush his/her own teeth? ❑ Yes ❑ No How often? _____ Floss? ❑ Yes ❑ No How often? _____

Does your child snack frequently? ❑ Yes ❑ No Does your child maintain a well-balanced diet? ❑ Yes ❑ No

Has your child experienced a toothache recently? ❑ Yes ❑ No

How do you expect your child to act this visit? _____

Has your child ever had an injury to his/her face or teeth? ❑ Yes ❑ No Date of injury: _____

If yes, please describe the incident/injury: _____

SIGNATURE/AGREEMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable, and any medical consultations deemed necessary with the patient's physician. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs, and all cost incurred in the collection of those fees, including collection agency fees, attorney fees, court costs, and venue to be held in Rutherford County. Signature on file for submission of insurance claims.

Your preferred contact method: ❑ Home Phone ❑ Cell Phone ❑ Text Message ❑ Email

Patient (Parent): _____ Date: _____

Reviewed by: _____ Date: _____

Wild About Smiles! Pediatric Dentistry & Orthodontics

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