

Welcome

Bowling Green Pediatric Dental Group, Inc.

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Health History Form

Today's Date: _____

NOTE: 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 Mi

Goes by: _____ Male Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

School _____ Grade _____

Child's Home # (_____) _____

SS# _____

Child's Home Address: _____

City _____ State _____ Zip _____

Email Address: _____

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

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

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 # (_____) _____

Cellular # (_____) _____

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 _____

Child 's Name _____

9. Dental History

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

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

Previous Dentist's Name _____

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**

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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

10 Health History

Has the child ever had any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease/Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Blood Disorders |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N HIV + / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Birth Defects | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Conditions |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Latex Product |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N 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**

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 _____
