PATIENT HISTORY FORM

Date _____

Patient's Name _____ Sex M ❑ F ❑ Age _____Yrs. _____Mos. Birth Date _____

Address _____ Height _____ Weight _____ Home Phone _____

Street City State Zip

CHILD'S DENTAL HISTORY

Yes	No	
❑	❑	IS THIS YOUR CHILD'S FIRST DENTAL VISIT? IF NO, HOW LONG SINCE LAST DENTAL EXAMINATION? _____
❑	❑	IS THIS AN EMERGENCY VISIT? IF YES, PLEASE EXPLAIN. _____
❑	❑	HAS YOUR CHILD HAD ANY UNFAVORABLE DENTAL EXPERIENCES?
❑	❑	HAVE ANY TEETH BEEN REMOVED BY A DENTIST?
❑	❑	DOES YOUR CHILD HAVE A PROBLEM WITH HIS/HER BITE OR POSITION OF TEETH?
❑	❑	HAS YOUR CHILD BEEN SEEN BY AN ORTHODONTIST?
❑	❑	HAS YOUR CHILD WORN ORTHODONTIC APPLIANCES?
❑	❑	HOW MANY TIMES A DAY DOES YOUR CHILD BRUSH HIS/HER TEETH? _____
❑	❑	IS DENTAL FLOSS USED?
❑	❑	IS FLUORIDE TAKEN IN ANY FORM? (WATER, TABLETS, ETC.)
❑	❑	DOES YOUR CHILD HAVE A HISTORY OF: (PLEASE CIRCLE) FINGER OR THUMB SUCKING, LIP SUCKING, NAIL BITING, USE OF PACIFIER?
❑	❑	HAVE THERE BEEN ANY INJURIES TO THE TEETH?

CHILD'S MEDICAL HISTORY

Yes	No	
❑	❑	IS YOUR CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES FOR WHAT REASON? _____
❑	❑	IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? MEDICINE: _____ DOSAGE: _____
❑	❑	IS YOUR CHILD SENSITIVE OR ALLERGIC TO ANY DRUGS, FOOD, OR OTHER? IF YES, PLEASE LIST:
❑	❑	IS YOUR CHILD ALLERGIC TO LATEX?
❑	❑	HAS YOUR CHILD HAD A HISTORY OF (PLEASE CIRCLE) HEART TROUBLE, RHEUMATIC FEVER, ASTHMA, SEIZURE DISORDER, KIDNEY OR LIVER DISEASE, CEREBRAL PALSY OR SPASTIC CONDITION, DIABETES, TUBERCULOSIS, PROFUSE BLEEDING, ANY COMMUNICABLE DISEASES, HEARING IMPAIRMENT, SPEECH IMPAIRMENT, MENTAL DISTURBANCE.
❑	❑	HAS YOUR CHILD HAD ANY CHILDHOOD DISEASES OTHER THAN CHICKEN POX, MEASLES OR MUMPS?
❑	❑	HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? REASON: _____
❑	❑	DOES YOUR CHILD HAVE A HANDICAP, LEARNING DISABILITY. OR OTHER SPECIAL PROBLEM? _____

NAME OF YOUR CHILD'S PHYSICIAN: _____

Yes	No	
❑	❑	WOULD YOU LIKE AN ORTHODONTIC EVALUATION FOR YOU OR YOUR CHILD?
❑	❑	WOULD YOU LIKE A REFERRAL TO A DENTIST FOR YOURSELF.

RESPONSIBLE PARTY INFORMATION – Signature Required

Name _____ Marital Status _____
Last First Middle

Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Email _____ Cell Phone _____

Previous Address (if less than 3 years) _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Occupation _____ Employer _____ # of Years at Present Job _____

*** I UNDERSTAND THAT THE ULTIMATE RESPONSIBILITY FOR ANY SERVICES RENDERED FOR THE PATIENT NAMED ABOVE ARE MINE.
IN THE EVENT THERE IS DENTAL INSURANCE COVERAGE, DAVIS PEDIATRIC DENTISTRY WILL ASSIST IN PROCESSING MY INSURANCE CLAIM. ***
*** I UNDERSTAND THAT, AT THE TIME SERVICES ARE RENDERED, PAYMENT MAY BE DUE IN FULL AND THAT
A FINANCE CHARGE MAY BE ASSESSED ON BALANCES CARRIED OVER 60 DAYS ***
*** ***THE OFFICE RESERVES THE RIGHT TO CONDUCT A CREDIT CHECK*** ***
*** I understand I am financially responsible whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should such action be required. ***
I agree that a photocopy of this authorization shall be valid as the original.

SIGNATURE OF RESPONSIBLE PARTY NAMED ABOVE _____

DO YOU HAVE DENTAL INSURANCE? ❑ Yes ❑ No CONFIDENTIAL (FOR RECORD AND PRETREATMENT EVALUATION)

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

ARE ANY OTHER FAMILY MEMBERS SEEN HERE? IF YES, PLEASE LIST THEIR NAMES: _____

ADDITIONAL FAMILY HISTORY (other than responsible party)

Child's Father _____ Height _____ Marital Status _____

Address _____ Home Phone _____
Street City State Zip

How Long at this address? _____

Previous Address (it less than 3 years) _____
Street City State Zip

Social Security # _____ Birth Date _____

Employer _____ Department _____ Work Phone _____

Child's Mother _____ Height _____ Marital Status _____

Address _____ Home Phone _____

How Long at this address? _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birth Date _____

Employer _____ Department _____ Work Phone _____

Name, Address, Telephone Number of Nearest Relative _____

_____

UPDATES (DATE AND INITIAL) _____ _____ _____ _____ _____ _____

I AUTHORIZE ROUTINE DENTAL DIAGNOSTIC PROCEDURES FOR MY CHILD.

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____ DATE _____

IN THE EVENT OF A PROPOSED TREATMENT PLAN, I ALSO AGREE TO THE USE OF ANESTHETICS, ANALGESICS, AND PREMEDICATIONS CONSIDERED NECESSARY OR ADVISABLE BY THE DENTIST FOR THE COMFORT AND WELL-BEING OF THE CHILD.

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____ DATE _____