Patient Information and Health History Form

PATIENT INFORMATION

Child's Name: _____ ☐ M / ☐ F Birth Date: _____

Address: _____

Best Phone Number: _____

Your child's primary language? _____ Your primary language? _____

Child's Physician/Pediatrician: _____ Phone: _____

Child's Previous Dentist: _____ Phone: _____

How did you hear about us? _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

GUARDIAN INFORMATION AND INSURANCE INFORMATION

☐ Mother / ☐ Stepmother / ☐ Guardian: _____ Full Name: _____

Occupation: _____ DOB: _____ SSN: _____

Address (if different than patient's): _____

☐ Work Phone / ☐ Cell: _____ Email: _____

What is the best way to reach you? _____

Dental Insurance Company: _____ Dental Insurance Phone Number: _____

Dental Insurance Address: _____

Group Number: _____ Subscriber ID: _____

☐ Father / ☐ Stepfather / ☐ Guardian: _____ Full Name: _____

Occupation: _____ DOB: _____ SSN: _____

Address (if different than patient's): _____

☐ Work Phone / ☐ Cell: _____ Email: _____

What is the best way to reach you? _____

Dental Insurance Company: _____ Dental Insurance Phone Number: _____

Dental Insurance Address: _____

Group Number: _____ Subscriber ID: _____

MEDICAL HISTORY

1. **Medical Conditions.** Does your child have a history of any of the following? (Check all that apply.)

☐ Arthritis	☐ Cleft Lip / Palate	☐ Hepatitis
☐ Asthma	☐ Down Syndrome	☐ HIV Infection/AIDS
☐ Diabetes	☐ Developmental Delay	☐ Tuberculosis
☐ Gastrointestinal Disorders	☐ Eating Problems	☐ STD (Sexually Transmitted
☐ Heart Disease	☐ Growth Problems	Disease)
☐ Heart Murmur	☐ Hearing Loss	☐ Cancer
☐ Kidney Disease	☐ Vision Problems	☐ Leukemia
☐ Rheumatic Fever	☐ Neuromuscular Defect	☐ Thyroid Problems
☐ ADD/ADHD	☐ Orthopedic Problems	☐ Fainting
☐ Anxiousness / Nervousness	☐ Seizures	☐ Sleep Apnea
☐ Autism	☐ Speech Problems	☐ Sleep Problems
☐ Behavior Issues	☐ Spina Bifida	☐ Snoring
☐ Emotional Problems	☐ Anemia	☐ Syndrome: _____
☐ Learning Problems	☐ Prolonged Bleeding	☐ Tobacco Use
☐ Psychiatric Disorder	☐ Hemophilia	☐ Exposure to Smoking
☐ Brain Injury	☐ Sickle Cell Disease	☐ Physical or Sexual Abuse
☐ Cerebral Palsy	☐Blood Transfusion	☐ Other

   If any boxes are checked, please describe further: _____

   _____

2. **Medications.** Is your child <u>currently</u> taking any medications? ☐ Y / ☐ N

   If yes, please list all medications: _____

   _____

3. **Allergies.** Does your child have any known **medication or food allergies**? ☐ Y / ☐ N

   If yes, please list all food and drug allergies: _____

   _____

4. **Developmental/Special Needs. Does your child:**

   Talk and understand at his or her age level? ☐ Y / ☐ N

   Go to a special class or school? ☐ Y / ☐ N

   Use a wheelchair or walker to help with walking? ☐ Y / ☐ N

5. **Immunizations.** Are your child's immunizations current? ☐ Y / ☐ N
6. **Antibiotics.** Have you ever been told the child needs to take antibiotics <u>before dental treatment</u>? ☐ Y / ☐ N
7. **Hospitalizations.** Has your child ever been hospitalized? ☐ Y / ☐ N

   If yes, please explain why and when: _____

8. **Surgeries.** Has your child had any operations? ☐ Y / ☐ N

   If yes, for what reason? _____

   Was your child put to sleep? ☐ Y / ☐ N And were there any complications? ☐ Y / ☐ N

   If yes, please explain: _____

DENTAL HISTORY

Reason for Dental Visit: _____

Date of Last Dental Visit: _____ Date of Last Dental X-ray: _____

Have there been **any issues with previous dental care**? If yes, please explain: _____

_____

Has your child had **local anesthesia (Novacaine, etc) allergic reaction**? ☐ Y / ☐ N

If yes, what was the allergic reaction? _____

Does your child:

Brush in the morning?	☐ Y / ☐ N	Brush at night?	☐ Y / ☐ N
Get help on brushing the teeth?	☐ Y / ☐ N	Use dental floss?	☐ Y / ☐ N
Use fluoride toothpaste or gel?	☐ Y / ☐ N	Take fluoride supplement?	☐ Y / ☐ N

How many **times a day** does your child snack? _____ What snacks? _____

How many **times a day** does your child usually drink each of the following?

Water: _____ Milk:_____ Juice:_____ Soda:_____

Have your child's teeth ever been injured? ☐ Y / ☐ N If yes, please describe the injury and treatment done:

_____

Does your child have any of the following habits?

Bottle to Sleep	☐ Y / ☐ N	Thumb or Finger Sucking	☐ Y / ☐ N	Pacifier Sucking	☐ Y / ☐ N
Teeth Grinding	☐ Y / ☐ N	Mouth Breathing	☐ Y / ☐ N		

Is there anything else you would like to tell us? _____

The information I have given is correct to the best of my knowledge, and I have truthfully revealed all aspects of my child's health history. I understand that any failure to have done so could have negative consequences for my child's health and the success of my child's treatment. I understand that it is my responsibility to inform Hurst Pediatric Dentistry of any changes to my child's medical/dental status.

I further confirm that am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I give consent for Dr. Jin Lin, associate dentists and dental staff to perform a dental exam, dental prophylaxis, fluoride treatment, and take x-rays on the child. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational, or research purposes.

_____ _____

Parent / Guardian Signature ***Date***

_____ _____

Name ***Relationship to Patient***