Child Health/Dental History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... 1. If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

FINANCIAL POLICY

We are proud to be a part of the team whose primary mission is to deliver you the finest and most comprehensive dental care available today. In addition, we are dedicated to making your top-quality care as cost effective as possible. To promote a long-term satisfying relationship, we have laid out our office financial policies below.

PAYMENT OPTIONS

- For all patients, payment liability for service is due at, or prior to the time services are rendered.
- For patients with insurance, we will collect any deductible and/or estimated co-payment at the time of service.
- We accept cash, check, Visa, MasterCard, Discover and American Express; we also offer financing through Care Credit and Lending Club.
- Any patient liability owed from previous treatment will be subject to payment plan contingent upon allowing our clinic to hold a credit card on file.

INSURANCE: As a courtesy to you, we will file a claim for payment with your insurance company.

- We will gladly discuss your proposed treatment, answer any questions related to your insurance and provide you with an **ESTIMATE** of what your insurance company will pay towards your treatment.
- Our office makes no guarantee of the actual payment by your insurance company, which may differ from the original estimate.
- Not all services we provide are covered benefits by insurance. Fees for non-covered services are due at, or prior to time of service.
- Your insurance is a contract between you, your employer and your insurance company; you are FULLY RESPONSIBLE for any charges for the treatment rendered and any differences between the original estimate and final bill.
- We will bill your secondary insurance as a courtesy but you are responsible for the estimated out of pocket related to the primary insurance.
- We do not bill medical insurances for services rendered at our clinic.

MISSED APPOINTMENTS

- For general dentistry appointments, a fee of $50 will be charged for all missed and short notice (less than 24-hour notice) cancelled appointments.
- For specialty appointments, a fee of $150 will be charged for all missed and short notice cancellations.
- Our office reserves the right to limit future appointments if short notice cancellations occur more than twice. Appointments are made on a per need basis and this time is reserved exclusively for you and your dental needs.

RETURNED CHECKS: A $25 charge will be applied when a check is returned from the bank

DENIED CREDIT CARD: A $25 charge will be applied when a credit card is denied when patient is on a payment plan

Primary Insurance Information:

Insurance Company: _____ Subscriber Name: _____

Subscriber's DOB: _____ Relationship: _____ ID#: _____ Group#: _____

Secondary Insurance Information:

Insurance Company: _____ Subscriber Name: _____

Subscriber's DOB: _____ Relationship: _____ ID#: _____ Group#: _____

Your signature below acknowledges that you received this form and you fully understand all of our policies.

Signature _____ Date _____