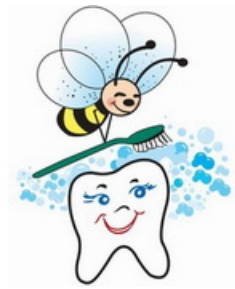


Welcome



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# _____

Email: _____

4. Father's Information

Name _____

Father Stepfather Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Email: _____

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 _____

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?

Lip Sucking / Biting Nail Biting

Nursing / Bottle Habits 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

10. Health History

Has the child ever had any of the following conditions?

Abnormal Bleeding Disabilities/Special Needs

Allergies to any Drugs Hearing Impairment

Any Hospital Stays Heart Disease/Murmur

Any Operations Hemophilia/Blood Disorders

Asthma Hepatitis

Cancer HIV + / AIDS

Congenital Birth Defects Kidney/Liver Conditions

Convulsions/Epilepsy Rheumatic/Scarlet Fever

Pregnancy Allergies to Latex Product

Tuberculosis Diabetes

ADD/ADHD Autism

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all allergies _____

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.

11. I hereby assign Dr. M.D. Alexander all money to which I am entitled for dental expense relative to the service rendered by him, but not to exceed my indebtedness to said dentist. It is understood that any money Received from the above insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by this agreement. I further agree in the event on non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required, and interest of 1-1/2% per month (18% apr.). Also, I authorize Dr. M.D. Alexander to render any treatment they deem necessary for my child's health, after having discussed treatment with me; including the use of nitrous oxide.

Signature of Parent or Guardian

Date

Relationship to Patient

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

