



# PATIENT HEALTH HISTORY

Thank you for giving us the privilege of serving your child's dental health needs. We are committed to providing the best possible care. Complete and thorough answers to the following questions will help make this possible. Thanks again for your cooperation.

PLEASE USE BLUE OR BLACK INK TO COMPLETE THIS FORM.

## PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F Child's SS #: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Parent e-mail address: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
Physician or Pediatrician: \_\_\_\_\_ Physician Phone#: \_\_\_\_\_  
Whom can we thank for referring you to this office: \_\_\_\_\_ Child's Interests: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Names and ages of brothers and sisters: \_\_\_\_\_

## PARENT / GUARDIAN INFORMATION

Father / Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Driver's License#: \_\_\_\_\_ SS#: \_\_\_\_\_  
Phone: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mother / Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Driver's License#: \_\_\_\_\_ SS#: \_\_\_\_\_  
Phone: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Do father, mother, and child all live together?  Yes  No If no, please explain: \_\_\_\_\_  
Nearest living relative other than parent / guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relation: \_\_\_\_\_ Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Person responsible for account: \_\_\_\_\_  
Insurance: Name of Insured: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_  
Mailing Address of Insurance Co.: \_\_\_\_\_

## MEDICAL INFORMATION: PLEASE ANSWER EVERY QUESTION

Yes No  
A.   Has your child ever been to the Emergency room? Explain: \_\_\_\_\_ Date: \_\_\_\_\_  
B.   Has your child ever been hospitalized? Explain: \_\_\_\_\_ Date: \_\_\_\_\_  
C.   Is your child now under the care of a physician? If so, why? \_\_\_\_\_  
D.   Is your child taking any medications? If yes, which ones? \_\_\_\_\_  
E.   Is your child allergic to anything? If yes, to what? \_\_\_\_\_  
F.   Has your child ever had a reaction to penicillin or any other drugs? If yes, what drugs? \_\_\_\_\_

Does your child now have or has he or she ever had any of the following:

Yes	No	Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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### Wild About Smiles! Pediatric Dentistry

# PATIENT HEALTH HISTORY (CONTINUED FROM PREVIOUS PAGE)

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## DENTAL HISTORY

Purpose of this visit: \_\_\_\_\_

Is today your child's first visit to the dentist?  Yes  No If no, give date of last visit: \_\_\_\_\_

What was done for your child at that time? \_\_\_\_\_

Have your child's teeth ever been X-rayed?  Yes  No If yes, by whom? \_\_\_\_\_

Has your child ever sucked his or her:  fingers  thumb  or pacifier? Is the habit still active?  Yes  No

Does your child have history of taking a bottle, nursing, and /or sippy cup after one (1) year of age?  Yes  No

Which of the following describes your home drinking water:  City water  Well water  Filtration system  County water

Does your child brush his or her own teeth?  Yes  No How often? \_\_\_\_\_ Floss?  Yes  No How often? \_\_\_\_\_

Does your child snack frequently?  Yes  No Does your child maintain a well balanced diet?  Yes  No

Has your child experienced a toothache recently?  Yes  No

How do you expect your child to act during this visit? \_\_\_\_\_

Has your child ever had injury to his or her face or teeth?  Yes  No Date of Injury: \_\_\_\_\_

If yes, please describe the incident/injury: \_\_\_\_\_

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## SIGNATURE / AGREEMENT

*This is to certify that I, the undersigned, consent to the performance of any and all procedures, the use of any and all drugs that are agreed to be necessary or advisable, and any medical consultations deemed necessary with the patient's physician. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs, and all cost incurred in the collection of those fees, including collection agency fees, attorney fees, court costs, and venue to be held in Rutherford County. Signature on file for submission of insurance claims.*

Your preferred contact method:  Home Phone  Cell Phone  Text Message  Email

Patient (Parent): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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### Wild About Smiles! Pediatric Dentistry

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