**Dental Care for Kids**

Martha “Jodi” Braid, DMD - Pediatric Dentist

*Dentistry for Children and Adolescents*

Health History Form Please Note: We *do not* file Third Insurances.

*For your convenience...* Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

# Tell Us About Your Child

Child’s Name

Last First Mi

Nickname Male Female Siblings that we treat

Child’s Birthdate / / Child’s Age Child’s Home # ( )

Social Security #

Child’s Home Address

Apt. / Condo #

City State Zip

Who does child live with? Mother Father

\*We expect to share all aspects of care with both parents listed unless we have restrictions in writing stating otherwise.

# Mother’s Information \*

Name

Stepmother Guardian DOB / /

Home Address (if different)

Apt. / Condo #

City State Zip

Employer

Work # ( ) Ext.

Home # ( ) Cell # ( ) Email

SS# DL #

Marital Status Single Married Separated Widowed Divorced

# Father’s Information \*

Name

Stepfather Guardian DOB / /

Home Address (if different)

Apt. / Condo #

City State Zip

Employer

Work # ( ) Ext.

Home # ( ) Cell # ( ) Email

SS# DL #

Marital Status Single Married Separated Widowed Divorced

# Who is Accompanying the Child Today?

Name Relationship

Do you have legal custody of this child? Yes No

Billing Address

Apt. / Condo #

City State Zip

Work # ( ) Ext.

Home # ( )

**The parent or Guardian who accompanies the child is responsible for payment at the time of service.**

***Please Note: The parent whose birthday falls first in the year (month) is primary.***

# Primary Dental Insurance

Insurance Co. Name Insurance Co. Address

Apt. / Condo #

City State Zip

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

# Secondary Dental Insurance

Insurance Co. Name Insurance Co. Address

Apt. / Condo #

City State Zip

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

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# Dental History

Is this your child’s first visit to the dentist? If not, how long since the last visit?

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?

Y N Lip Sucking/Biting Y N Nail Biting

Y N Nursing Bottle Habits Y N Thumb/Finger Sucking

Has the child ever had a serious or difficult circumstance associated with previous dental work? 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 Does the child floss his/her teeth daily? Yes No

# Health History

Has the child ever had any of the following?

Y N Abnormal bleeding Y N Handicaps/disabilities Y N Allergies to any drugs Y N Hearing impairment Y N Any hospital stays Y N Heart murmur

Y N Any operations Y N Hemophilia

Y N Asthma Y N Hepatitis

Y N Cancer Y N HIV+ / AIDS

Y N Congenital Heart Disease Y N Kidney/liver problems Y N Convulsions/Epilepsy Y N Rheumatism/scarlet fever Y N Pregnancy Y N Allergy to latex product

Y N Autism Y N ADHD Y N Sleep Apnea

Please explain any serious medical conditions the child has had

Please list all drugs the child is currently taking

Please list all drugs the child is allergic to

Child’s Physician Phone # ( )

Is the child currently under the care of a physician? Y N

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.

Who may we thank for referring you to our office?

1. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child’s medical status. I authorize the

dental team to perform the necessary dental services my child may need.

Signature of Parent or Guardian Date Relationship to Patient

1. Insurance Payment Authorization and Financial Agreement:

I hereby authorize my insurance benefits to be paid to the undersigned dentist. I understand that I am financially responsible for any unpaid balance on my account for 90 days. If any balance is overdue and legal assistance becomes necessary, the responsible party will be liable

for all charges incurred.

Signature of Parent or Guardian Date

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