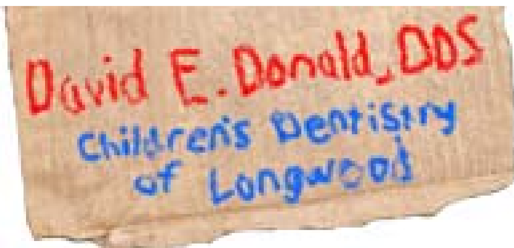

365 Wekiva Springs Rd
Suite 121
Longwood, FL 32779
Phone: 321-295-7893

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?

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 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?

Y N Abnormal Bleeding	Y N Disabilities/Special Needs
Y N Allergies to any Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorders
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + / AIDS
Y N Congenital Birth Defects	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Diabetes
Y N ADD/ADHD	Y N 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 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 staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian   Date   Relationship to Patient

For Office Use Only

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

Initials ____________ Date ______________

Doctor's Comments ______________________________

____

____

____