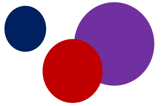
JUST KIDZ DENTISTRY PC

Health History Form



We are delighted to have you as a new patient. May we extend our sincere thanks for the opportunity to meet your child's dental needs. We look forward to a continued relationship with you!

WELCOME TO OUR PRACTICE!

1 Tell Us About Your Child

Child's Name ___________________________________

Nickname______________________________________

★ Male ★ Female

Birthdate___________________Age_______________

Mobile/Home #_________________________________

SS#____

Home Address__________________________________

____

____

2 Mother's Information

Name ____

★ Mother ★ Stepmother ★ Guardian

Birthdate_____________________________________

Employer_____________________________________

M#___________ H#___________Othr# __________

SS#____

3 Father's Information

Name ____

★ Father ★ Stepfather ★ Guardian

Birthdate_____________________________________

Employer_____________________________________

M#___________ H#___________Othr# __________

SS#____

4 Who is Accompanying the Child

Name ____

Relationship __________________________________

Do you have legal custody of this child?

★ Yes ★ No

5 Person Responsible for Account

Name ____

Relationship___________________________________

Billing Address_________________________________

____

M#__________ H#___________ Othr# __________

E-mail_______________________________________

6 Primary Dental Insurance

Ins. Co. Name__________________________________

Address______________________________________

____

Ins. Co. Phone#_________________________________

Group #______________________________________

Policy Owner's Name_____________________________

SS# or ID# ___________________________________

Policy Owner's Employer _________________________

____

7 Secondary Dental Insurance

Ins. Co. Name__________________________________

Address______________________________________

____

Ins. Co. Phone#_________________________________

Group #______________________________________

Policy Owner's Name_____________________________

SS# or ID# ___________________________________

Policy Owner's Employer _________________________

____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

8 Dental History

Is this your child's first visit to the dentist? ___________

If not, how long since the last dental exam? ___________

Were x-rays taken at previous dental visit? ___________

Have there been any injuries to the teeth,
face or mouth? ★ Yes ★ No

If yes, please explain: ______________________________

____

Why did you bring your 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 Finger habit

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 any fluoride supplements? ★ Yes ★ No

Has the child ever had any pain or tenderness in his/her jaw? ______________________________

Does the child brush his/her teeth daily? ★ Yes ★ No

Floss his/her teeth daily? ★ Yes ★ No

Is he/she active in sports? ★ Yes ★ No

9 Health History

Has the child ever had any of the following problems?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Disease
Y N Convulsions/Epilepsy
Y N Rheumatic/Scarlet Fever
Y N Frequent ear infections
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV/AIDS
Y N Kidney/Liver Problems
Y N ADD/ADHD
Y N Allergies to Latex
Y N Autism

Please discuss any serious medical problems the child has had______________________________

____

____

Please list all the drugs the child is taking

____

Please list all allergies

____

Is the child currently under the care of a physician?

____

Child's Physician ______________________________

Phone #______________________________

Please describe the child's current physical health

★ Good ★ Fair ★ Poor

10

Tell us how you heard about Just Kidz Dentistry: ______________________________

____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest 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.

Printed Name of Parent or Guardian: ______________________________

Signature of Parent or Guardian: ______________________________

Date: ______________________________

Relationship to Patient: ______________________________

Email & Text Appointment Reminders!- We invite you to participate in our online system.

Email: ______________ Email Opt OUT ☐ Parent/Guardian Initial _______

Mobile:______________ Text Opt OUT ☐ Parent/Guardian Initial _______

"We're in this together!"