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	
❑	❑	Rheumatic Fever	❑	❑	Tuberculosis	❑	❑	Cerebral Palsy	❑	❑	AIDS
❑	❑	Heart disease	❑	❑	Anemia	❑	❑	Hepatitis	❑	❑	Eye problems
❑	❑	Heart murmur	❑	❑	Thyroid disease	❑	❑	Diabetes	❑	❑	Hearing problems
❑	❑	Liver disease	❑	❑	Blood transfusion	❑	❑	Epilepsy	❑	❑	Speech problems
❑	❑	Asthma	❑	❑	Sickle cell disease or trait	❑	❑	Birth defects	❑	❑	Cleft lip/palate
❑	❑	Respiratory disease	❑	❑	Blood disorders	❑	❑	Kidney disease	❑	❑	Other Special Needs:_____
❑	❑	Cancer	❑	❑	Autism	❑	❑	Bladder disease			

Wild About Smiles! Pediatric Dentistry

Dr. Joy Mckee • Dr. Chad Curry • Dr. David Stanley • Dr. Lisa Stanley • Dr. Jason Vogt

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PATIENT HEALTH HISTORY (CONTINUED FROM PREVIOUS PAGE)

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:_____

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 prefered contact method: ❑ Home Phone ❑ Cell Phone ❑ Text Message ❑ Email

Patient (Parent): _____ Date: _____

Reviewed by: _____ Date: _____

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