CHILD HEALTH/DENTAL HISTORY FORM

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

CHILD'S HISTORY

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

_____

_____

_____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Dental Insurance Information

Does patient carry dental insurance? ☐ Yes ☐ No

Primary Insurance Information

Last Name: _____First Name: _____MI:_____

Relationship to Patient: _____

SS#:_____Driver's License #:_____

DOB:_____

Employer:_____Address:_____

Dental Insurance:_____ID#_____Group #:_____

Medical Insurance:_____ID#:_____Group #:_____

Secondary Insurance Information (complete only if patient is covered by a secondary insurance company)

Last Name: _____First Name: _____MI:_____

Relationship to Patient: _____

SS#:_____Driver's License #:_____

DOB:_____

Employer:_____Address:_____

Dental Insurance:_____ID#_____Group #:_____

Medical Insurance:_____ID#:_____Group #:_____

Patient Safety and Privacy

For your comfort one adult is welcome, but not required, to accompany your child to the operatory. We do encourage independence to help promote the growth and development of your child. All others, including children not scheduled at this appointment, are asked to remain in the reception area to maintain the safety and privacy of other patients. Young children in the reception area will need adult supervision. Please refrain from bringing strollers into the treatment area as they tend to block common pathways. The use of cell phones is prohibited in the operatory. The extra conversation carried on by others in the clinical area can be distracting to other children and can prevent us from providing close attention to each young patient. We thank you for your understanding and consideration in these matters.

Acknowledgement of Privacy Practices (see HIPAA at time of check-in)

I certify that I have received a copy of SmileBuilders Children's Dentistry's Notice of Privacy Practices:

Signature:_____Date:_____

Printed Name:_____

Relationship to Patient:_____

Appointment Policy

Scheduled appointments are reserved specifically for your child. If you need to cancel your appointment, please call 24 hours in advance so that we may give that appointment to another pa
We ask that you arrive 15 minutes or more prior to your child's appointment to fill out any additional paperwork so that we can see your child on time. If you arrive 15-20 minutes late to your appointment, you may be asked to reschedule for the next available appointment time. A parent or legal guardian (with official documentation) must be present with the patient at the initial examination.

Consent for Dental Treatment

I request and authorize Dr. Rashedi to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental xrays as may be considered necessary by Dr. Rashedi to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Rashedi and the staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using a variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature:_____Date:_____

Printed Name:_____

Relationship to Patient:_____