Child's Health History

General Information

Patient Information:

Name:_____ Nickname:_____
Date of Birth_____ Male: ☐ Female: ☐
Address:_____ City:_____
State:_____ Zip:_____ Home Phone #:_____

Parent or Guardian Information:

Father:_____ SS#:_____
Occupation:_____ Employer:_____
Work Address:_____
Work Phone#_____ Cell Phone #:_____
Mother:_____ SS#:_____
Occupation:_____ Employer:_____
Work Address:_____
Work Phone#:_____ Cell Phone#:_____

Dental Insurance Information:

Primary Insurance: Employee:_____ Relationship:_____
Insurance Company:_____ Employer:_____
Union or Group #:_____ ID#_____

Secondary Insurance: Employee:_____ Relationship:_____
Insurance Company:_____ Employer:_____
Union or Group #:_____ ID#_____

Person to contact in case of an emergency:_____
How did you hear about our office:_____

Tell us about your child:

Favorite toys, hobbies, activities or interests:_____
_____
Brothers/sisters: Name_____ Age:_____
Name:_____ Age:_____
Name:_____ Age:_____
Name:_____ Age:_____

Child's Health Information

Child's Physician:_____
Date of last medical exam:_____
Has your child ever been hospitalized:_____
If so: When?_____Why?_____
When?_____ Why?_____
Is your child taking any prescription meds now?_____
Is so: What kind?_____Why?_____
What kind?_____Why?_____
Does your child have allergies?_____To what?_____
Please list any allergies to medicine:_____
Does your child use fluoride?_____ ☐Rinse ☐Tablets
Name(s) of parents dentist:_____

Place a check if your child has a history of or difficulty with any of the following:

☐ Anemia	☐ Epilepsy	☐ Liver Disease
☐ Asthma	☐ Fainting	☐ Muscle or Bone Disease
☐ Birth Defect	☐ Hearing	☐ Rheumatic Fever
☐ Bleeding Disorders	☐ Heart Trouble	☐ Scarlet Fever
☐ Blood Transfusions	☐ Hepatitis	☐ Speech Problems
☐ Cerebral Palsy	☐ HIV Positive	☐ Thyroid
☐ Convulsions	☐ Immune System	☐ Tuberculosis
☐ Diabetes	☐ Kidney Disease	☐ Other_____

Does or did your child have a thumb or finger sucking habit? ☐Yes ☐No
If yes, what age did it stop?_____
Does or did your child have a pacifier habit? ☐ Yes ☐ No
If yes, what age did it stop?_____
Ear Infections? ☐ Yes ☐ No If yes, how many in a year?_____
Were tonsils removed? ☐Yes ☐ No If yes, at what age?_____
Were adenoids removed? ☐ Yes ☐ No If yes, at what age?_____
Any additional information that may help us in caring for your child:_____
_____

(Please read and *INITIAL* the following statements)

_____I acknowledge that if my account becomes delinquent and goes to collections, I will be charged an additional 45% of the total collection amount.
_____I acknowledge that if a check is returned from the bank, I will be charged a $25 fee.
_____I acknowledge that if I cancel with less than 24 hours notice or do not show for my appointment, there will be a $50 fee.
_____I understand that Delmarva Dental Services is a non participating provider with all insurance companies. Delmarva Dental Services will bill my insurance company for me but if said insurance company sends the check to me, I am responsible to forward this payment to Delmarva Dental Services. Any amount not paid by the insurance company will become my responsibility and I will pay the balance promptly.
_____I understand that I am responsible for all fees incurred by me or my dependants at Delmarva Dental Services.
_____The above medical history is complete and accurate. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding the medical profile.

Name:_____ ☐ **Parent** ☐ **Legal Guardian**

Signature:_____**Date:**_____

SUBMIT