Park Dental OF MARTINSVILLE

Pediatric Dentistry Health History Form

Child's Full Name: _____ Nickname: _____ Sex: M F

Date of Birth: ____/____/_____ Age: _____ Social Security #: ____/____/_____ Home Phone (_____)_____

Address: _____
Street City State Zip

Grade: _____ School: _____ City: _____

Name(s) and ages of other children in family: _____

Name(s) of your other children seen in this office: _____

Please list the child's hobbies / interests: _____

Whom may we thank for referring you? _____

Who is accompanying the child today? _____ Relation: _____

Who has legal custody of this child? _____

Parent/Legal Guardian Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

☐ **Mother** ☐ **Step Mother** ☐ **Guardian**

Name: _____ Driver's License #: _____State_____

Date of Birth: _____ Social Security #: _____

Address: _____
Street City State Zip

Home Phone #: (_____)_____ Work Phone #: (_____)_____

Cell #(_____)_____Email -_____

Employer: _____

Dental Insurance: Yes___ No___ Company_____

☐ **Father** ☐ **Step Father** ☐ **Guardian**

Name: _____ Driver's License #: _____State_____

Date of Birth: _____ Social Security #: _____

Address: _____
Street City State Zip

Home Phone #: (_____)_____ Work Phone #: (_____)_____

Cell / Mobil / Pager / Other Phone #(_____)_____

Employer: _____

Dental Insurance: Yes___ No___ Company_____

Emergency Contact

His / Her Name: _____ Relation: _____

Work Phone #: (_____)_____ Home Phone #: (_____)_____

Cell / Mobil / Pager / Other Phone #(_____)_____

Address: _____
Street City State Zip

Medical History

Child's Physician:_____

Phone #: (_____)_____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? □ Yes □ No

If yes, please explain: _____

_____

Please describe the child's current physical health: □ Good □ Fair □ Poor

Are Immunizations Current? □ Yes □ No

Please list all medications that the child is currently taking: _____

Please list all medications / foods / other that cause the child allergic reactions: _____

Has the child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding	Y N Cleft Palate / Lip	Y N Hepatitis Type ____
Y N AIDS/HIV+	Y N Diabetes	Y N High / Low Blood Pressure
Y N Anemia	Y N Epilepsy / Seizures	Y N Hives
Y N Any Hospital Stays/Surgeries	Y N Handicaps / Disabilities	Y N Kidney Problems
Y N Asthma	Y N Hearing / Speech	Y N Liver Problems
Y N Blood Transfusion	Y N Heart Disease	Y N Rheumatic Fever
Y N Cancer	Y N Heart Murmur	Y N Sickle Cell Anemia
Y N Cerebral Palsy	Y N Hemophilia Type ____	Y N Tuberculosis (TB)

Please discuss the above and any other medical problems the child has / had: _____

_____

_____

Do you consider your child to be: □ Progressing normally in the learning process □ Slow in the learning process

Dental History

What is the ***primary*** reason for today's visit? _____

Is your child currently having problems with any of the following?

□ Cavities	□ Toothache	□ Sensitive Teeth	□ Trauma
□ Gum Infection	□ Color of Teeth	□ Tooth Alignment	□ Other _____

Has the child experienced problems with previous dental work? □ Yes □ No Explain: _____

Is the child's home water supply fluoridated? □ Yes □ No

Does the child brush his / her teeth daily with fluoride toothpaste? □ Yes □ No

Do you give the child any other form of fluoride? □ Yes □ No If yes, what? _____

Does the child floss his / her teeth daily? □ Yes □ No

Was your child bottle / breast-fed? □ Yes □ No If yes, what age was it completely stopped? _____

Does your child suck a finger / thumb / pacifier / or exhibit any other habits? _____

Previous/Present (circle) Dentist: _____ Date of last Visit: _____

Why did you leave your last dentist? _____

What did you like most about any dentist you have seen?_____ Least?_____

_____

Signature _____ Date _____

Relationship to Child _____

Park Dental
OF MARTINSVILLE
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Martinsville, NJ 08836
Tel: 732.377.9690
www.MartinsvilleDentistry.com

AUTHORIZATIONS AND CONSENT

APPOINTMENTS - In order to provide each child with the individual care and attention that they deserve, we ask that you arrive on time for scheduled dental appointments. We work very hard to see each patient at their scheduled appointment time.

We require twenty-four (24) hours notice if you must change a scheduled dental appointment. Less than 24 hours notice, or not showing for an appointment, is considered a missed appointment. Missing a scheduled appointment is counterproductive for both the patient and our office. A fee of $25.00, or more, may be assessed for each missed appointment.

PAYMENT - Payment can be made by cash, check, Discover Card, MasterCard, or VISA. Fees for any treatment diagnosed will be discussed with you at your initial appointment. Payment arrangements/finance options are available through our office.

INSURANCE - Please provide the front office staff with your insurance card so that we can contact your insurance company regarding your benefits. We will file your insurance claims and work with your insurance company concerning their portion of treatment fees. Remember, even if you have insurance coverage, you are responsible for payment of your account. Your insurance coverage is a relationship between you, the insured patient, and your insurance company. We have no influence over your coverage.

CONSENT FOR DENTAL TREATMENT - I request and authorize Dr. Park and his staff to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the talking of dental x-rays as may be considered necessary by Dr. Park to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Park and his staff will provide an environment designed to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

I have reviewed the information on the Health History Form and it is accurate to the best of my knowledge. I understand that this information 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 agree to inform the office of any changes in address, phone, employment, etc that occur during the course of treatment for my child. If the patient is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____ Legal Guardian (if different): _____