



Palm Beach Pediatric Dentistry, P.A.

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Caring for your child's oral health through prevention, quality treatment, and positive motivation.

Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First Mi
Nickname _____ Male Female
Siblings that we treat _____
Child's Birthdate ____/____/____ Child's Age _____
Child's Home # (_____) _____
SS# _____
Child's Home Address: _____

APT. / CONDO #

City State Zip

2. Mother's Information

Name _____
 Stepmother Guardian Birthdate ____/____/____
Employer _____
Work # (_____) _____ Ext. _____
Home # (_____) _____
Cellular Phone # (_____) _____
SS # _____ DL# _____

3. Father's Information

Name _____
 Stepfather Guardian Birthdate ____/____/____
Employer _____
Work # (_____) _____ Ext. _____
Home # (_____) _____
Cellular Phone # (_____) _____
SS # _____ DL# _____

Marital Status Single Married Separated
 Widowed Divorced

4. Who is Accompanying the Child Today?

Name _____
Relationship _____
Do you have legal custody of this child? Yes No

5. Person Responsible for Account

Name _____
Relationship _____
Billing Address _____

City State Zip
Home # (_____) _____
Work # (_____) _____
E-mail _____

6. Primary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____

Insurance Co. Phone # (_____) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthdate ____/____/____
Social Security # _____
Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____

Insurance Co. Phone # (_____) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthdate ____/____/____
Social Security # _____
Policy Owner's Employer _____

8. Dental History

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

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

Why did you bring the 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 Thumb / Finger Sucking

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 fluoride supplements? **Yes** **No**

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

joint? (TMJ/TMD)? **Yes** **No**

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

Floss his / her teeth daily? **Yes** **No**

9. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding Y N Handicaps/Disabilities

Y N Allergies to any Drugs Y N Hearing Impairment

Y N Any Hospital Stays Y N Heart Murmur

Y N Any Operations Y N Hemophilia

Y N Asthma Y N Hepatitis

Y N Cancer Y N HIV + / AIDS

Y N Congenital Heart Disease Y N Kidney/Liver Conditions

Y N Convulsions/Epilepsy Y N Rheumatic/Scarlet Fever

Y N Pregnancy Y N Allergies to Latex Product

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all drugs the child is allergic to _____

Child's Physician _____

Phone (_____) _____

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

Please describe the child's current physical health...

 **Good**  **Fair**  **Poor**

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

Who may we thank for referring you to our office? _____

10. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of 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. I agree to pay for all treatment at the time of service and understand that receipts will be furnished for insurance reimbursement to the insured.**

Signature of Parent or Guardian _____

Date _____

Relationship to Patient _____

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Insurance Verification: **Effective Date** ____/____/____

Preventive _____% **Deductible \$** _____

Basic _____% **Maximum \$** _____

Major _____% **Electronic Claims** **Yes** **No**

Doctor's Comments _____

Does insurance cover sealants (1351)? **Yes** **No**

If yes, what do they fall under? _____