

# Welcome



## Health History Form

103 Fluor Daniel Dr. ♦ Sugar Land, TX 77478  
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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 ser-

### 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: \_\_\_\_\_  
City State Zip  
Who does the child live with? \_\_\_\_\_

### 2. Who may we thank for referring you to our office?

\_\_\_\_\_

### 3. Mother's Information

Name \_\_\_\_\_  
Mother Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Marital Status \_\_\_\_\_  
Address \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_  
Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_  
SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 4. Father's Information

Name \_\_\_\_\_  
Father Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Marital Status \_\_\_\_\_  
Address \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_  
Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_  
SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 5. Who is Accompanying the Child Today?

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

### 6. Person Responsible for Account

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Billing Address \_\_\_\_\_  
City State Zip  
Home # (\_\_\_\_\_) \_\_\_\_\_  
Work # (\_\_\_\_\_) \_\_\_\_\_  
Cellular # (\_\_\_\_\_) \_\_\_\_\_  
E-mail \_\_\_\_\_

### 7. 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 \_\_\_\_\_  
Insurance ID# \_\_\_\_\_

### 8. 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 \_\_\_\_\_  
Insurance ID# \_\_\_\_\_

## 9. 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

Has your child had an orthodontic evaluation?       Yes       No

## 10. 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 Disease/Murmur

Y  N Any Operations       Y  N Hemophilia/Blood Disorders

Y  N Asthma       Y  N Hepatitis

Y  N Cancer       Y  N HIV + / AIDS

Y  N Congenital Birth Defects       Y  N Kidney/Liver Conditions

Y  N Convulsions/Epilepsy       Y  N Rheumatic/Scarlet Fever

Y  N Pregnancy       Y  N Allergies to Latex Product

Y  N Tuberculosis       Y  N Diabetes

Y  N Behavioral / Learning Disorders

Please discuss any serious medical conditions the child has had

\_\_\_\_\_

\_\_\_\_\_

Please list all drugs the child is currently taking and why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Emergency contact not living with you:

\_\_\_\_\_

Phone# \_\_\_\_\_

**11.** 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.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

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

## For Office Use Only

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

Initials \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_