Dependent Health History

The following information is required to be filled out accurately and completely to become a patient of record. Please do not leave any lines blank. Feel free to ask any staff member if you have any questions.

PATIENT INFORMATION

First Name ______________________ MI ____ Last Name ____________________
Birthdate _______/______/_______ SS# ____________________ ☐ Male ☐ Female
Home Address ____
Home Phone ( ) - __________ Best time to call ________________________

PARENT/LEGAL GUARDIAN INFORMATION

Name of parent or legal guardian bringing dependent to office:
First Name ______________________ MI ____ Last Name ____________________
Birthdate _______/______/_______ SS# ____________________ ☐ Male ☐ Female
Home Address ____
Home Phone ( ) - __________ Best time to call ________________________
Marital Status ☐Single ☐ Married ☐ Divorced ☐ Widowed
Employer ____________________________ Occupation ____________________
Address ____
Work Phone ( ) - __________ Cell Phone ( ) - __________
Person to contact in an emergency ________________________________
Emergency contact phone # ( ) - __________ Relationship ________________

INSURANCE INFORMATION

Whose dental insurance is covering this dependent, if any? ☐ My own ☐ Spouse's ☐ Parent ☐ None
Insurance Carrier ____________________________ Group # ________________
Address ____
Phone ( ) - __________ Deductible $ ________ Max Annual Benefit $ ________

MEDICAL INFORMATION

Dependent's Doctor: ______________________ Doctor's Phone: ( ) __________
List of current medications: ____
____

Please list any allergies and/or adverse reactions: ____________________________
____

Serious hospitalizations or surgeries? ________________________________

Turn over to complete this form

❖ **Have you had or currently have any of the following conditions? Please check all that apply:**
(All patient information is highly confidential)

____High Blood Pressure	____Thyroid Disease	____Glaucoma	____Artificial Hip/Joint
____Heart Murmur	____Arthritis/Gout	____Hemophilia	____Lung Disease
____Rheumatic Fever	____Stroke	____Chemotherapy	____AIDS (HIV)
____Heart Attack	____Diabetes	____Ulcers	____Asthma
____Mitral Valve Prolapse	____Psychiatric Care	____Heart Surgery	____Kidney Trouble
____Liver Disease/ Cirrhosis	____Blood Disease	____Fainting	____Tuberculosis
____Drug/Alcohol Abuse	____Epilepsy/Seizures	____Hepatitis	____Cancer
____Anemia	____Cardiac Pacemaker	____Allergies	____Sexually Transmitted Disease

____Other: (please list) ____

Please list any other medical issues: ____

____

DENTAL INFORMATION

Has your son/daughter/dependent ever been to the dentist before? ☐ Yes ☐No
If yes, when was their last exam? ____________
Do you have any specific concerns about their teeth or mouth? ☐ Yes ☐No
Please specify: ____
Have they ever had a bad dental experience ☐ Yes ☐No
Have they ever had his/her teeth sealed to prevent decay? ☐ Yes ☐No
Are you considering braces for your child? ☐ Yes ☐No
Has your son/daughter seen an orthodontist before? ☐ Yes ☐No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or omitting information can be dangerous to my dependent's health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I verify that I have received and understand the patient information pamphlet. I agree to abide by all policies set forth in the patient information pamphlet. Please note that without 24 hours notice, we reserve the right to charge for appointments cancelled or not attended. Patients who are more than 15 minutes late for their appointment may be rescheduled and assessed a missed appointment fee.

____ ____________________
Signature of Parent/Legal Guardian Date

1. ______ DATE	______ INITIAL	2. ______ DATE	______ INITIAL	3. ______ DATE	______ INITIAL
4. ______ DATE	______ INITIAL	5. ______ DATE	______ INITIAL	______	

Changes to History(office use only)