

## Medical Dental History Form for Patients 18 years and Under

## Patient and Family Information

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  Male  Female

Social Security# \_\_\_\_\_ Home Phone \_\_\_\_\_

Home address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Responsible Party \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Name of Mother/Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security# \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Name of Father/Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security# \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

## Child's Dental History

Former Dentist \_\_\_\_\_ Office Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

Please check all that apply to your child:

Thumb/Finger Sucking  Fingernail Biting  Grinding Teeth

Lip or Cheek Biting  Jaw Difficulty: Clicking and/or Pain

## Child's Health History

Please check all that apply to your child:

Allergies  Diabetes  Hepatitis - Type \_\_\_\_\_  Tuberculosis

Anemia  Epilepsy  Rheumatic Fever  Other \_\_\_\_\_

Asthma  HIV/AIDS  Scarlet Fever \_\_\_\_\_

Cancer  Heart Murmur  Tonsillitis

Primary Dental Insurance

Person Responsible for Account
Relationship to Patient Birthdate
Social Security# Home Phone
Address
City State Zip
Employer Business Phone
Business Address Occupation
Insurance Company
Insurance Company Address
Subscriber I.D. # Group #

Additional Insurance

Person Responsible for Account
Relationship to Patient Birthdate
Social Security# Home Phone
Address
City State Zip
Employer Business Phone
Business Address Occupation
Insurance Company
Insurance Company Address
Subscriber I.D. # Group #

Assignment and Release

I hereby authorize payment directly to
for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party Date