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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 ☐ Tonsilitis

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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 ______________