DENTAL CARE OF SALINA
CHILD HEALTH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be some additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: ____________________________________ SS#:_________________ DOB: ________________
If you are completing this form for another person, please list your name & relation to the patient:
Your Name: ________________________________ Relationship to Patient: ______________________
Home Address: _____________________________ City, State & Zip Code________________________
Home/Cell Phone: ___________________________ Business Phone: ___________________________
Employer: __________________________________ Position: _________________________________
Primary Insurance Company: __________________ Policy Holder: _____________________________
Policy Holder DOB: ___________________________ Relation to Pt: ____________________________
Secondary Insurance Company: ________________ Policy Holder: _____________________________
Policy Holder DOB: ___________________________ Relation to Pt: ____________________________

Whom may we thank for referring you into our office? ____

HEALTH HISTORY:
Primary Care Physician & Phone Number: ____
Has your child been treated or hospitalized for any reason in the past 2 years? _____________________
If yes, please describe: ____
Please list all medication your child is currently taking: ____
____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

Y / N Abnormal Blood Pressure
Y / N Asthma
Y / N HIV
Y / N Diabetes
Y / N Bleeding Problems
Y / N Tuberculosis
Y / N Heart Problems
Y / N Hepatitis
Y / N Heart Disease

ALLERGIES TO (please circle): Penicillin Codeine Local Anesthesia Jewelry Latex/Rubber
Please list any other allergies:____

DENTAL HISTORY:
When was your child's last dental visit? _______________ What was done at that time? _____________
What dentist(s) has your child seen in the past? ____
What kind of dental experiences has your child had? ____
How often does your child brush their teeth? _______________________ Floss? __________________
Has your child had orthodontic treatment (braces)? Y / N Doctor's Name: ________________________

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

Y / N Crowded Teeth
Y / N Grinding of Teeth
Y / N Missing Teeth
Y / N Loose Teeth
Y / N Frequent Cavities
Y / N Bad Breath
Y / N Noticeable wear on teeth
Y / N Popping/clicking Jaw
Y / N Loose/lost fillings

How do you feel about your child's smile? ____
If you could change anything about your child's smile, what would you change? ____________________

Please provide us with anything else you feel is important: _______________________________________
____
____

AUTHORIZATION:
I understand that I am responsible for any balance for services that are not covered by my insurance, and I may be billed for the remaining balance. I consent & agree that I am responsible for payment of all services rendered on my behalf & on behalf of my dependents (if any).
I authorize this office to release information including diagnosis and records of treatment for myself and my dependent(s) to my insurance carriers, payers, and/or my healthcare practitioners. I authorize the payment from my insurance carrier to submit directly to this office and applied directly to my account.
As a condition of treatment, financial arrangements will be made in advance. Financial responsibility on the part of each patient will be determined prior to treatment.
A finance charge of 18% can be applied to any account that is 60 days past due, unless previous arrangements have been made.

I grant permission for this office to contact me by phone to discuss my account or my treatment.

Signature of Patient (or representative: _____________________________ Date: _______________
Relationship to Patient: ____