DENTISTRY FOR CHILDREN
TROY L. KING, D.D.S.

Health History Form **Today's Date:** ______________

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ______________________________
Last First MI

Goes by: ____________________ ☐ Male ☐ Female

Siblings that we treat ______________________________

Child's Birthdate _____/_____/_____ Child's Age __________

School__________________________Grade__________

Child's Home # (__________)______________________________

SS#______________________________

Child's Home Address:______________________________

____
City State Zip

Email Address:______________________________

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

____

3. Mother's Information

Name ______________________________

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer ______________________________

Work # (_________)__________________ Ext. __________

Home # (_________)______________________________

Cellular Phone # (_________)______________________________

SS # __________________ DL# __________________

4. Father's Information

Name ______________________________

Father Stepfather Guardian Birthdate _____/_____/_____

Employer ______________________________

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 ______________________________

8. Secondary Dental Insurance

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

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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 ______________________________

9. Dental History

Is this your child's first visit to the dentist? ______________________

If not, how long since the last visit to the dentist? ______________________

Previous Dentist's Name ______________________

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?

Lip Sucking /Biting   Nail Biting

Nursing/Bottle Habits   Thumb/Finger Sucking

Has the child ever had serious or difficult problem associated with previous dental work? Yes / No

If yes, please explain ______________________

	YES	NO
Is the child's water fluoridated?	☐	☐
Is the child taking fluoride supplements?	☐	☐
Has the child ever had any tenderness or pain in his/her jaw/joint ***(TMJ/TMD)***?	☐	☐
Does the child brush his/her teeth daily?	☐	☐
Floss his/her teeth daily?	☐	☐
Is the child adopted?	☐	☐

10. Health History

Has the child ever had any of the following conditions?

- Y N Abnormal Bleeding
- Y N Allergies to any Drugs
- Y N Any Hospital Stays
- Y N Any Surgeries
- Y N Asthma
- Y N Cancer
- Y N Congenital Birth Defects
- Y N Convulsions/Epilepsy
- Y N Kidney/Liver Condition
- Y N Allergies to Latex products
- Y N Handicaps/Disabilities
- Y N Hearing Impairment
- Y N Heart Disease/Murmur
- Y N Hemophilia
- Y N Hepatitis
- Y N HIV+/AIDS
- Y N Diabetes
- Y N Pregnancy
- Y N Chronic Illness
- Y N Tuberculosis

Behavioral/Learning Disabilities

- Y N Learning Disabilities
- Y N Development Delays
- Y N Mental Illness
- Y N Autism

If yes, Please explain any serious conditions the child has had – ______________________

Please list all drugs the child is currently taking: ______________________

Please list all drugs the child is allergic to: ______________________

Child's Physician ______________________

Phone (   ) ______________________

Is the child currently under the care of a physician? ______________________

Please describe the child's current physical health:
Good ***Fair*** ***Poor***

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

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

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 ______________________