Welcome

Carl A Trout DDS PC

pediatric DENTISTRY

Health History Form

For your convenience… Print this form, complete all information, and bring it with you on your first visit to our office. 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

Nickname_____ ☐ Male ☐ Female

Hobbies_____

Siblings that we treat _____

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

Child's Home # (_____)_____

Child's Home Address:_____

_____
City State Zip

2. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate _____/_____/_____

Address (if different from child's)_____

_____
City State Zip

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____

Marital Status:

☐ Single ☐ Married ☐ Partnered ☐ Widowed
☐ Divorced ☐ Separated

3. Father's Information

Name _____

Father Stepfather Guardian Birthdate _____/_____/_____

Address (if different from child's)_____

_____
City State Zip

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____

Marital Status:

☐ Single ☐ Married ☐ Partnered ☐ Widowed
☐ Divorced ☐ Separated

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

_____

_____

5. Ways in which we can communicate with you:

Phone _____

Text_____

Email_____

6. Relative or Friend not living with you

Name_____

Relationship_____

Phone # _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Subscriber ID # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Subscriber ID # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Policy Owner's Employer _____

Today's Date:_____

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9. Dental History

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

Date of your child's last visit to the dentist? _____

Who was your child's previous dentist?_____
Name

_____
Address Phone

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?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

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

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

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 Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD
Y N Allergies to Metal/Nickel
Y N Special Needs/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Artificial Bones/Joints/Valves

Please discuss any serious medical 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? Yes No

Please describe the child's current physical health...

Good **Fair** **Poor**

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

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

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 _____

_____

_____

_____