HEALTH HISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

	YES	NO
ANEMIA	_____	_____
ASTHMA	_____	_____
CANCER	_____	_____
HEPATITIS	_____	_____
HIV/AIDS	_____	_____
HEMOPHILIA	_____	_____
ABNORMAL BLEEDING	_____	_____
ALLERGIES	_____	_____
ALLERGIES PENICILLIN	_____	_____
ALLERGIES TO ANESTHETIC	_____	_____
HANDICAPS/DISABILITIES	_____	_____
TUBERCULOSIS	_____	_____
DIABETES	_____	_____
RHEUMATIC FEVER	_____	_____
CONGENITAL HEART DEFECT	_____	_____
HEART MURMUR	_____	_____
CONVULSION/EPILEPSY	_____	_____

PLEASE EXPLAIN ANY MEDICAL PROBLEMS THAT YOUR CHILD HAS____

____

CHILD'S ORAL HYGIENE ROUTINE/HABITS

HOW OFTEN DOES YOUR CHILD BRUSH?____

HOW OFTEN DOES YOUR CHILD FLOSS?____

DOES YOUR CHILD

SUCK THUMB/FINGER	YES	NO
SUCK/BITE LIPS	YES	NO
BITE/CHEW NAILS	YES	NO
CHEW HARD OBJECTS (I.E. PENCILS)	YES	NO
GRIND TEETH	YES	NO
WEAR A MOUTHGUARD FOR SPORTS	YES	NO

TO THE BEST OF MY KNOWLEDGE THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY CHILD'S HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS.

I ALSO AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES MY CHILD MAY NEED.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN____DATE____________________

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THE INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN:____DATE____________________

PAYMENTS OF ALL DENTAL FEES ARE THE PRIMARY RESPONSIBILITY OF THE PATIENT/PARENT. ALL SUCH PAYMENTS SHALL BE MADE DIRECTLY TO OUR OFFICE. WE WILL BE HAPPY TO ASSIST IN PREPARING THE NECESSARY FORMS TO HELP COLLECT BENEFITS FROM INSURANCE COMPANIES, BUT IT SHALL BE THE ULTIMATE AND PRIMARY RESPONSIBILITY OF THE PATIENT/PARENT TO SUBMIT THE NECESSARY FORMS AND SECURE BENEFITS THAT MAY BE DUE.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

IN THE EVENT OF NON-PAYMENT FROM THE INSURANCE COMPANIES THE UNDERSIGNED AGREES TO PAY ALL THE COSTS OF THE DENTAL SERVICE RENDERED.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN____DATE____________________