Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

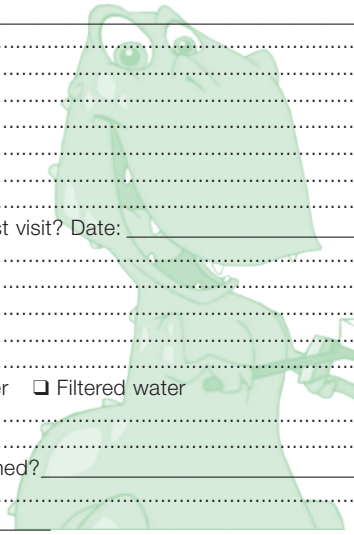
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

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or go online at www.adacatalog.org

PATIENT INFORMATION

Name:_____

Last First Middle Initial

Date of Birth:_____ **SSN:**_____

Marital Status: Single Married Divorced Widowed Domestic Partner

Address:_____**City**_____**State**_____
Zip Code_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Email:_____ **Employer:**_____

Emergency Contact:_____ **Phone Number:**_____

Relationship to patient:_____

INSURANCE INFORMATION

Dental Insurance Company:_____

Employer:_____ **Subscriber:**_____

Relationship to patient:_____ **Subscriber DOB:**_____

Subscriber SSN or ID No.:_____ **Phone Number:**_____

Address (if different from patient):_____

Do you have additional/secondary dental insurance? If so, Name and subscriber:_____

_____

FINANCIAL POLICY

Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment the patient is responsible for the portion the insurance does not cover. Please be aware that some insurance companies may not cover all services performed in our office. The patient is responsible for all charges that are denied or unpaid by your insurance carrier. Most dental insurances have limits and/or various degrees of co-payments.

INSURANCE COVERAGE: I understand my dental insurance is a contract between the insurance carrier and the patient, not between doctors and the insurance carrier. NO INDIVIDUAL in this office can predict what our insurance will or will not pay. Insurance companies indicate that there is no guarantee of coverage until the actual claim is received. Therefore, I will be responsible for payments that a third party may refuse to pay. _____Initials

PAYMENT TERMS: I understand that I am financially responsible for all charges incurred by my dependents and /or myself AT THE TIME SERVICES ARE RENDERED. I agree that in the event my account is past due ninety days from the date of service, I will be turned over to a collection agency unless arrangements are made in advance. Late charges and collection agency charges do apply. We accept cash, checks, MasterCard, Visa, American Express, and Discover. A fee of $35.00 will be charged on all returned checks. _____Initials

CANCELLATION POLICY: I understand that if I am unable to keep an appointment, I must kindly provide Cottingham Family Dentistry with a minimum of two (2) business days. This courtesy on your part will make it possible to give your appointment to another patient who needs to be treated by the dentist or hygienist. Our policy is after three missed appointments you will be required to pre-pay for all future services before an appointment time is held.
_____Initials

PROTECTED HEALTH INFORMATION:

Please distinguish any person/persons to whom you authorize Cottingham Family Dentistry to release your **protected health and/or financial information**. **Please be specific:**

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (you may refuse to sign this acknowledgement):

I have received a copy of this office's Notice of Privacy Practices (HIPAA):

_____ _____

Signature Date

CONSENT TO TREATMENT: I give Cottingham Family Dentistry the authority to administer xrays, local injections, and anesthetics in relation to any needed treatment. If I have a medical condition, such as a heart murmur or artificial joint that requires premedication, or drug allergy, I acknowledge that it is my responsibility to inform and remind the Doctor, Assistant or Hygienist every time before treatment. Please advise our office of ANY and ALL medications you may be taking especially any blood thinners.

_____ _____

Signature Date