Welcome

Kerber Smiles
PEDIATRIC DENTISTRY
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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

Siblings that we treat _____
Child's Birthdate _____/_____/_____ Child's Age _____
Child's Home # (_____)_____
SS#_____
Child's Home Address:_____
_____
City State Zip

Is the child Adopted or a Foster Child?_____

Child lives with: Mom Dad Both Joint Custody
Other (If so whom)_____

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

_____

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate _____/_____/_____

Address_____

_____or circle: same as above for child.

Employer _____
Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepfather Guardian Birthdate _____/_____/_____

Address if different from address above for the child:_____

_____

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 _____

_____

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 _____

Name:_____

9. Dental History

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

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

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 Developmental Delay
Y N Emotional Disorder
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 Autism
Y N ADD/ADHD

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**

Please explain any other special needs the child has:_____

_____

_____

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.

I agree to be responsible for all charges not paid by the dental insurance and I hereby authorize release of any information relating to this claim to the dental insurance and I also authorize payment of the dental benefits otherwise payable to me directly to the dental entity. I understand that the parent or guardian who accompanies the child is responsible for the payment of charges.

_____ _____ _____

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.