PINE RIDGE DENTAL
WILDERNESS RIDGE
EDGEWOOD

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HEALTH HISTORY
CHILD FORM

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Child's name _____ (Last / First / MI) Today's Date _____

Preferred name _____ ❑ Male ❑ Female

Referred to Pine Ridge Dental through _____

Birthdate _____ Age _____ Social Security Number _____

Home address _____ (Street / City / State / Zip)

Person responsible for child's account _____ Relationship _____

Billing address _____ Employer _____

Please check preferred mode(s) of contact for parent/guardians:

❑ Home phone _____ ❑ Work phone _____ Ext _____

❑ Mobile phone _____ ❑ Text messaging _____

❑ E-mail _____ May we call a parent/guardian at work if needed? ❑ Yes ❑ No

Person outside the home to contact in case of emergency _____ Phone _____

Please provide any names of individuals authorized to receive information on this child:

Name / Phone / Address

Name / Phone / Address

DENTAL INSURANCE

Does patient have dental insurance? ❑ Yes ❑ No

Coverage through ❑ Parent ❑ Other _____

Primary Insurance Holder's Name _____

Primary Ins. Holder's Birthdate _____

Primary Ins. Holder's Social Security # _____

Primary Ins. Holder's Employer _____

Primary Ins. Holder's Insurance Co. _____

Subscriber ID# _____

Secondary Insurance coverage is through

❑ Parent ❑ Other _____

Secondary Ins. Holder's Name _____

Secondary Ins. Holder's Birthdate _____

Secondary Ins. Holder's Social Security # _____

Secondary Ins. Holder's Employer _____

Secondary Ins. Holder's Insurance Co. _____

Subscriber ID# _____

Please take the time to fill out medical history on reverse

Child's Medical History

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

Approximate date of child's last doctor visit _____

Is your child currently under the care of any physician? ❑ Yes ❑ No

If yes, please explain _____

Is your child presently taking any medications prescribed by a physician or dentist?

❑ Yes ❑ No If yes, please list or attach on a separate sheet

For teens, are you pregnant? ❑ Possibly ❑ Yes ❑ No If yes, Week #_____

Does your child need to be premedicated with antibiotics before dental treatment?

❑ Yes ❑ No *(This is to prevent bacterial endocarditis after joint replacement or due to congenital heart disease, prosthetic heart valves or other heart conditions; final confirmation of the need for premedication should be made by your physician).*

Has your child had any serious medical problems? ❑ Yes ❑ No

If yes, please explain _____

Check box if your child had any history of, or conditions related to, any of the following

- ❑ Heart
- ❑ Cerebral Palsy
- ❑ Epilepsy/seizures
- ❑ HIV+/AIDS
- ❑ Tuberculosis
- ❑ Fainting spells
- ❑ Cancer/Tumors
- ❑ Radiation treatment
- ❑ Kidney disease
- ❑ Psychiatric disorders
- ❑ Arthritis
- ❑ Hypothyroid
- ❑ Asthma/respiratory problems
- ❑ Sickle cell disease
- ❑ Transplant
- ❑ Hearing problems
- ❑ Growth problems
- ❑ Bladder
- ❑ Diabetes
- ❑ Tobacco use, *how much?*_____
- ❑ Chronic hepatitis
- ❑ Hemophilia/bleeding
- ❑ Drug/alcohol abuse
- ❑ Chemotherapy
- ❑ Dental anxiety
- ❑ Liver disease
- ❑ Anemia
- ❑ Chronic sinus problems
- ❑ Hyperthyroid
- ❑ Fever blisters/cold sores
- ❑ Human papilloma virus
- ❑ Chicken pox
- ❑ Sight problems
- ❑ **NONE**

OFFICE USE ONLY **Doctor's comments** _____

Has your child experienced any that are not listed above? ❑ Yes ❑ No

If yes, please list _____

Is your child allergic to any medications or products? ❑ Yes ❑ No

If yes, please list _____

Dental History

Why have you come to the dentist today? _____

If this is not your first visit, when were your child's teeth last cleaned?

Has your child had complications or difficulties with previous dental treatment?

❑ Yes ❑ No If yes, please explain _____

What type of water do you drink? (check all that apply)

❑ City ❑ Well ❑ Bottled ❑ Filtered

Does your child participate in physical recreational activities? ❑ Yes ❑ No

If you have dental insurance, do you let the insurance dictate what treatment your child should receive? ❑ Yes ❑ No

Do you have suggestions on how Pine Ridge Dental can best meet your needs?

❑ Yes ❑ No If yes, please explain _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

HIPAA ACKNOWLEDGMENT

Parent/Guardian Received	Parent/Guardian Refused

Parent or Guardian Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

24 hour cancellation notice required or charge will be made.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

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