Mary Jo McGuire, DMD
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.

## 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 #: _____

Child's Home Address: _____

_____
Apt./Condo #

_____
City State Zip

## Mother's Information

Name: _____

Birthdate: _____/_____/_____

Employer: _____

Work #: _____ Ext. _____

Home #:_____

Cell #: _____

Email:_____

## Father's Information

Name: _____

Birthdate: _____/_____/_____

Employer: _____

Work #: _____ Ext. _____

Home #:_____

Cell #: _____

Email:_____

Parent Marital Status: ✪ Single ✪ Married ✪ Separated ✪ Widowed ✪ Divorced ✪ Other

## Who is Accompanying the Child Today?

Name: _____

Relationship: _____

Do you have legal custody of this child? ✪ Yes ✪ No

## Primary Dental Insurance

Policy Owner's Employer: _____

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 or Subscriber ID# _____

## Secondary Dental Insurance

Policy Owner's Employer: _____

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 or Subscriber ID# _____

## 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

## 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 Heart Disease
Y N Convulsions/Epilepsy
Y N PDD / Autism
Y N Pregnancy
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
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 Speech Problems

Please discuss any serious medical conditions the child has had:

_____

_____

Please list all drugs the child is currently taking: _____

_____

Please list all food or 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

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

Who may we thank for referring you to our office? _____

_____

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

## 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_____

_____

_____

_____