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Creating Generations of Smiles

Child History Form for the Office of Marvin Rosenberg D.D.S.

Today's date:_____

General Information

Patient name:_____ Age:_____ Date of Birth:_____

Nickname: _____ Sex: ☐ Male ☐ Female

Social Security #:_____

School: _____ Grade: _____

Hobbies / Sports: _____

Musical Instruments played: _____

Home Address:_____

_____ Tel.( )_____
City State Zip

Name of person(s) accompanying child today? _____ Relationship _____

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

List brothers / sisters with age: _____

Parent's marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mother's name: _____ Cell # ( )_____

Mother's Address:_____Tel.( )_____
Employer: _____ Wk. #: _____
Office Address: _____ How long? _____

Father's name: _____ Cell # ( )_____

Father's Address: _____ Tel.( )_____
Employer: _____ Wk #: _____
Office Address: _____ How long? _____

Person Responsible for the Account:

Name: _____ Relationship: _____

Billing Address: _____

Whom may we Thank for referring you?_____

Names of other family members seen by us?_____

Family Dentist:_____ Last Visit Date:_____

What are your concerns about your child's teeth? _____

_____

Medical History:

Family Physician: _____ Last Visit Date: _____

Has your child had any of the following?

Y N Anemia
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma / Arthritis
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Congenital Heart Defects
Y N Diabetes / Tuberculosis
Y N Difficulty Breathing
Y N Drug / Alcohol Abuse
Y N Emphysema / Glaucoma
Y N Epilepsy/Seizures / Fainting Spells
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart surgery / Pacemaker
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers / Colitis
Y N Venereal Disease

Please discuss any medical problems that your child has had:_____

_____

Your child's current general health is: ☐ Good ☐ Fair ☐ Poor

Y N Is your child currently under the care of a physician? If yes, reason _____

Y N Is your child currently taking any medication? If yes, describe _____

Y N Is your child allergic to any medications? (E.g.: aspirin, penicillin, etc.) If yes, _____

Y N Have adenoids or tonsils been removed? When?_____

Y N Has puberty begun?

Y N Has menstruation begun? (Girls)

Dental History:

Y N Has your child ever experienced pain/discomfort in the jaw joint (TMJ)?

Y N Does your child clench / grind their teeth?

Y N Have there been any injuries to the: Face Mouth Teeth Chin (please circle)

Y N Does your child brush his / her teeth daily? Y N Floss daily?

Y N Does your child have any missing or extra permanent teeth?

Your child's current dental health is: ☐ Good ☐ Fair ☐ Poor

Does / did your child have any of the following habits: (Please circle all that apply)

Lip sucking/biting ; Mouth breathing ; Nail biting ; Speech problems ; Thumb/ Finger sucking ; tongue thrust

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 in my child's medical status. *I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.*

_____

Signature Date

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

Signature Date

INSURANCE INFORMATION

Primary:

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relationship _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Secondary:

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relationship _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____