4 Burton Lane
Suite 400
Mullica Hill, NJ
08062

PediatricDentistry
Of Mullica Hill

Health History Form

Today's Date: ____________________

NOTE: 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

Goes by: ____________________ Male Female

Siblings that we treat ______________________________

Child's Birthdate _____/_____/_____ Child's Age __________

School______________________________Grade__________

Child's Home # (__________)______________________________

SS#______________________________

Child's Home Address:______________________________

____
City State Zip

2. Who May We Thank for Referring You?

____

3. Mother's Information

Name ______________________________

Mother Stepmother Guardian Birthdate ____/_____/_____

Email Address:______________________________

Employer ______________________________

Work # (__________)____________________ Ext. __________

Home # (__________)______________________________

Cellular Phone # (__________)______________________________

SS # ____________________ DL# ____________________

4. Father's Information

Name ______________________________

Father Stepfather Guardian Birthdate ____/_____/_____

Email Address:______________________________

Employer ______________________________

Work # (__________)____________________ Ext. __________

Home # (__________)______________________________

Cellular Phone # (__________)______________________________

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 ______________________________

9. Dental History

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

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

Previous Dentist's Name______________________________

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 Thumb / Finger Sucking Y N Nail Biting

Y N Pacifier Y N Lip Sucking / Biting

Y N Nursing / Bottle Habits Y N Grinding

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 ADD / ADHD Y N Disabilities / Special Needs

Y N Anemia Y N Epilepsy / Seizure Disorder

Y N Auto Immune Disease Y N Hearing Impairment

Y N Asthma / Reactive Airway Y N Heart Murmur

Y N Autism Spectra Y N Heart Problems

Y N Behavioral Disorder Y N HIV + / AIDS

Y N Bleeding Disorder Y N Kidney/Liver Conditions

Y N Cancer Y N Pregnancy

Y N Celiac Disease Y N Reflux

Y N Developmental Delays Y N Rheumatic / Scarlet Fever

Y N Diabetes Y N Sensory Processing Disorder

Please discuss or add any medical conditions the child has had

____

____

Please list all drugs the child is currently taking______________

____

____

Please list all ALLERGIES______________________________

____

Please list any Hospital Stays or Operations ______________

____

____

Child's Physician ______________________________

Phone (____________)______________________________

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

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 ______________________________

____

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