

Welcome

Children's Dental Associates, PC

607 Chestnut Street
Philadelphia, PA 19106
215-925-6251

7847 Old York Rd
Elkins Park, PA 19027
215-635-5560



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 _____

Email Address: _____

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

*If found on the Internet, where did you find us?
(search engine, directory)*

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Email: _____

4. Father's Information

Name _____

Father Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Email: _____

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?

Lip Sucking / Biting Nail Biting

Sleeping with a bottle 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?

Abnormal Bleeding Disabilities/Special Needs

Allergies to any Drugs Hearing Impairment

Any Hospital Stays Heart Disease/Murmur

Any Operations Hemophilia/Blood Disorders

Asthma Hepatitis

Cancer HIV + / AIDS

Congenital Birth Defects Kidney/Liver Conditions

Convulsions/Epilepsy Rheumatic/Scarlet Fever

Pregnancy Allergies to Latex Product

Tuberculosis Diabetes

ADD/ADHD Autism

Please discuss any serious medical conditions the child has had _____

Please list all drugs the child is currently taking _____

Please list all allergies _____

Child's Physician _____

Phone (_____) _____

Address _____

City State Zip

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.

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.

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 _____
