

New Patient Child Medical and Dental History

We value our patient's privacy and would never sell, share, or rent your personal information. It is used solely for the purpose of providing you with excellent service and assisting with your insurance. Please mark duplicate family information with ".

1) Tell us about your Child

Patient's Legal Name: _____ M / F Birthdate: ___/___/____
Preferred Name (If Different than Above): _____ Social Security #: _____

2) Responsible Party

Marital Status: Married, Divorced, Single, Widowed

Name: _____ M / F Birthdate: ___/___/____
Preferred Name (If Different than Above): _____ Social Security #: _____
Street Address: _____ City: _____ State: ___ Zip: _____
Marital Status: Married, Divorced, Single, Widowed Preferred Contact Method: Call, Text, Email
Cell/Home #: _____ Work #: _____ Email: _____

3) Tell us about your Insurance: Please provide a legal form of identification and insurance cards to utilize your benefits.

Primary Dental Insurance or Patient does not have dental insurance

Policy Owner's Name: _____ Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/____ Social Security # _____

Secondary Dental Insurance or Patient does not have secondary dental insurance

Policy Owner's Name: _____ Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/____ Social Security # _____

Medical Insurance or Patient does not have medical insurance

Policy Owner's Name: _____ Relationship to Patient: _____
Policy Owner's Birthdate: ___/___/____ Social Security # _____

4) Dental History

Is this your child's first visit to the dentist? Yes - No

Reason for child's visit: _____

Has your child ever had issues or complications associated with previous dental or medical treatment? Yes - No

Note: _____ Yes - No

Does the child brush his/her teeth daily? Yes - No

Have there been any injuries to the teeth, face, or mouth? Yes - No

Does the child have any of the following habits? Yes - No

Pacifier Use / Lip Sucking / Nail Biting / Nursing Bottle / Thumb or Finger Sucking

Has the child ever had any pain in his/her jaw joint TMJ/TMJJD? Yes - No

Has the child had any orthodontic treatment? Yes - No

Does the child participate in active recreational activities? Yes - No

Does the child utilize a fluoride toothpaste or fluoride supplement? Yes - No

Do you have a personal stance on fluoride use? _____

5) Health History

Has your child experienced a change in general health in the past year? Yes - No

Is your child presently under care of a physician for a medical issue? Yes - No

Pediatrician's Name: _____ Phone Number: _____

Is your child taking medication regularly? Yes - No

Please List Medications: _____

Is your child sensitive or allergic to anything? (e.g. aspirin, penicillin, latex, sulfa,) Yes - No

Please Explain: _____

Has your child had any history of, or conditions related to any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Yes - <input type="checkbox"/> No: Joint Replacement
(hip, knee, elbow, finger) | <input type="checkbox"/> Yes - <input type="checkbox"/> No: High Cholesterol | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Sleep Apnea |
| <input type="checkbox"/> Yes - <input type="checkbox"/> No: Artificial
(prosthetic) heart valve | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Pacemaker | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Sleep Disorder |
| <input type="checkbox"/> Yes - <input type="checkbox"/> No: Previous Infective
Endocarditis | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Abnormal Bleeding | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Mental Health
Disorders |
| <input type="checkbox"/> Yes - <input type="checkbox"/> No: Damaged valves and/or
transplanted heart | <input type="checkbox"/> Yes - <input type="checkbox"/> No: AIDS or HIV Infection | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Severe Headaches /
Migraines |
| <input type="checkbox"/> Yes - <input type="checkbox"/> No: Congenital Heart
Disease (CHD)
- Unrepaired, cyanotic CHD | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Autoimmune Disease | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Sexually Transmitted
Disease |
| - Repaired Complete CHD date ___ | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Asthma | <input type="checkbox"/> Yes - <input type="checkbox"/> No: History of
Bisphosphonates Drugs |
| - Repaired CHD with residual
defects | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Cancer
Surgery / Chemo / Radiation | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Other: _____ |
| <input type="checkbox"/> Yes - <input type="checkbox"/> No: Heart attack | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Chronic Pain | _____ |
| <input type="checkbox"/> Yes - <input type="checkbox"/> No: Low / High Blood
Pressure | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Diabetes Type I or II | _____ |
| | <input type="checkbox"/> Yes - <input type="checkbox"/> No: G.E. Reflux/Persistent
Heartburn / Stomach issues | _____ |
| | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Fainting Spells or
Seizures | _____ |
| | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Liver Dysfunction | _____ |
| | <input type="checkbox"/> Yes - <input type="checkbox"/> No: Neurological Disorders | _____ |

If yes, please explain: _____

Has your child ever had a negative experience with medical or dental treatment? Yes - No
 Has it ever been required or recommended that your child take an antibiotic pre-medication prior to dental
 treatment? Yes - No
 Please provide an explanation for every yes response. Any information you can provide will help us take
 better care of your child. _____

6) Authorization

I request and authorize dental treatment and procedures including the taking of dental x-rays and use of local anesthetics and/or nitrous oxide as may be necessary. **Initial: _____**
 I understand that Heritage Oak Dental will bill my insurance as a courtesy but that I am ultimately responsible for all charges should my insurance company not pay for any reason. I also understand that my portion is due at the time treatment is rendered.
 I hereby authorize payment of dental benefits to Shane Douglas DDS PC. **Initial: _____**
 I understand that I must provide Heritage Oak Dental with at least 24 business hours' notice of a change/cancellation to my appointment to avoid a \$50-\$250 "broken appointment fee" or loss of "nonrefundable deposit." **Initial: _____**
 I acknowledge that I received and reviewed the following documents: Dental Material Fact Sheet, Financial Policy, and Notice of Privacy Practices. Activities at Heritage Oak Dental may be monitored by video surveillance. **Initial: _____**

7) How did you hear about us? _____

X _____ Date: ___ / ___ / ____
 Signature of Parent/Guardian/Responsible Party

For Completion by Your Doctor

Comments: _____

- PreMed (Amox, Clind, Other) Allergies (Aspirin, Codeine, Ibuprofen, Erythro, Latex, Penicillin, Sulfa, Other) Airway Do ASA(I, II, III, IV, V)
Autoimmune Ds Behavioral Do Bleeding Do BMI Diabetes (I, II) Epilepsy BisphosHx Mallampati (I, II, III, IV)
Dental (AntiFluoride, Anxiety, Bruxism, CRL, CRM, CRH, Habit, Ortho, Perio, Poor OH, Sensitivity, Soft Tissue) Heart Ds Radi/Chemo Kidney Ds
Liver Ds See MedHx See Meds Stomach Do TMJD Pregnant/Nursing Botox Dermal Fillers Medical Billing

Reviewed By: _____ NV: _____