PARK AVE SMILE

120 E 62nd STREET
SUITE 1D
NEW YORK, NY 10065
212-759-3666

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.

3. Mother's Information

Name

Mother ☐ Stepmother ☐ Guardian ☐ Birthdate / /

Employer

Work # ( ) Ext.

Home # ( )

Cellular Phone # ( )

SS # DL#

Email address:

4. Father's Information

Name

Father ☐ Stepfather ☐ Guardian ☐ Birthdate / /

Employer

Work # ( ) Ext.

Home # ( )

Cellular Phone # ( )

SS # DL#

Email address:

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?

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]

10. Health History

Has the child ever had any of the following conditions?

[Y] [N] Abnormal Bleeding	[Y] [N] Handicaps/Disabilities
[Y] [N] Allergies to any Drugs	[Y] [N] Hearing Impairment
[Y] [N] Any Hospital Stays	[Y] [N] Heart Disease/Murmur
[Y] [N] Any Operations	[Y] [N] Hemophilia/Blood Disorders
[Y] [N] Asthma	[Y] [N] Hepatitis
[Y] [N] Cancer	[Y] [N] HIV + / AIDS
[Y] [N] Congenital Birth Defects	[Y] [N] Kidney/Liver Conditions
[Y] [N] Convulsions/Epilepsy	[Y] [N] Rheumatic/Scarlet Fever
[Y] [N] Pregnancy	[Y] [N] Allergies to Latex Product
[Y] [N] Tuberculosis	[Y] [N] Diabetes

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking

Please list all 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

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 _____

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

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 _____