Welcome

Myriam Cerezo
295 Buck Road
Suite 201
Holland, PA
Phone: 215-942-9090

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?

_____

3. Mother's Information

Name _____

☐Mother ☐Stepmother ☐Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

Email:_____

4. Father's Information

Name _____

☐Father ☐Stepfather ☐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?

☐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 Disabilities/Special Needs
☐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
☐Y☐N ADD/ADHD	☐Y☐N 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 (_____) _____

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 _____

_____

_____

_____