CHILD HEALTH HISTORY (ages 14 and younger)

A COMPLETE AND ACCURATE HEALTH HISTORY IS ESSENTIAL FOR PROPER DENTAL CARE

Your cooperation in accurately completing this confidential questionnaire is appreciated.

Please print Child's Name: _____

Who is your Child's Physician? _____ **Doctor's Office/Location** _____

Date of last complete physical exam: _____ **Doctor's Phone Number** _____

MEDICAL HISTORY *(Place an X under "Yes" or "No")*

	YES	NO
Is your child currently under medical treatment?	_____	_____
Is your child taking any medicines?	_____	_____

List their medications _____

Your child has or had:	YES	NO
Heart Problems	_____	_____
Diabetes	_____	_____
Asthma/Breathing problems	_____	_____
Hepatitis (A, B, C, …)	_____	_____
Bleeding Problems	_____	_____
Anemia	_____	_____
Cancer- please explain	_____	_____

Other – please explain _____

_____

Is your child allergic to:	YES	NO
Penicillin	_____	_____
Other Antibiotics	_____	_____
Latex	_____	_____
Local Anesthetic/Novocaine	_____	_____
Codeine	_____	_____
Aspirin	_____	_____
Other	_____	_____

Please comment below if there are any physical, medical, or emotional problems for which your child has been treated or which give you concern as a parent?

_____

_____

	YES	NO
Does your child have a finger sucking habit?	_____	_____

Is your child involved in any of the following programs?

Speech Therapy	_____	_____
Special Education	_____	_____
Physically Handicapped	_____	_____

_____ _____

PARENT OR GUARDIAN'S SIGNATURE **DATE**

Patient's Name:_____
FIRST MIDDLE LAST

Home Address:_____
STREET TOWN ZIP

Patient's date of Birth: _____

Parent/Guardian's Name:_____ **Parent/Guardian's Home#:**_____

Parent/Guardian's Work#:_____ **Parent/Guardian's Cell#:**_____

Parent/Guardian's E-mail Address: _____

Whom may we thank for referring you to our office?_____

OUR OFFICE POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Office Policy, which we require you read and sign prior to any treatment. All patients must complete our Medical History before seeing the doctor. Please let us know if you have any questions or concerns.

Regarding Insurance

We may accept assignment of insurance benefits. However, your portion of the bill is to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services.

Patients Without Insurance

Full Payment is due at time of service. We accept cash, checks, or VISA/MASTERCARD/AMERICAN EXPRESS.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, American Express, or payment by cash or check at time of service has been verified.

Missed Appointments

Unless canceled, at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Interest

We reserve the right to charge interest in the amount of 1.5% as provided by state law.

I have read the Office Policy. I understand and agree to this Office Policy:

_____ _____
SIGNATURE DATE

Does the patient have dental insurance? **YES** **NO**

Name of the Insurance Company_____

Insured Parent's Name_____

Insured Parent's Date of Birth_____

Insured Parent's Insurance I.D./Soc. Sec.#_____

Group Number_____