Paulson DENTAL

Child's Information & Health History

We would like to welcome you to our practice. Our goal is to help improve and maintain maximum oral health. Please fill out this form completely. Thank you for choosing us for your dental health care needs.

INITIAL EXAM

Date: _____

Child's Name: _____ Date of Birth: _____
(Nickname if any)

Child's Address: _____ Child's Phone: _____
City State Zip

Hobbies, Sports and Interests: _____

Person Responsible for this account: _____ Relationship to child _____

Residence Address: _____ Residence Phone: _____
City State Zip

Employed By: _____ Business Phone: _____

Business Address: _____ S. S. # : _____
City State Zip

INSURANCE

Please give Insurance Card to Front Desk

How did you hear about us: _____

_____

Dental Insurance Plan (If Any) _____

Subscriber: _____ Date of Birth: _____

CHILD'S DENTAL HISTORY

Dental History: _____ Last check-up date: _____

Dental Concerns: _____

Any previous unfavorable dental experience ❑ YES ❑ NO

Explain: _____

Does the child have or use any of the following - circle Y-yes or N-no

Y N Traumatic injury to mouth or health
Y N Teeth sensitive to cold, heat, sweets, or pressure
Y N Bleeding gums
How long? _____
Y N Clenching or grinding of teeth
Y N Swelling or lumps in mouth
Y N Bad breath
Y N Complications from extractions
Y N Topical Fluoride Treatment
Y N Orthodontic treatment
Y N Mouth breathing
Y N Oral habits: thumb sucking, fingernail biting, cheek biting, etc.

MEDICAL HISTORY

Physicians Name: _____ Date of last Physical Exam: _____ Child's Age: _____

Does the child have or use any of the following - circle Y-yes or N-no

Y N Allergy to Penicillin
Y N Allergies to drugs
Y N Allergies to anesthetics
Y N Any heart ailments
Y N Radiation Treatments
Y N Excessive bleeding from cut or extractions
Y N Anemia or blood problems
Y N Asthma
Y N Hay fever or allergies in general
Y N Diabetes
Y N Kidney problems
Y N Liver problems or hepatitis
Y N Malignancies or Leukemia
Y N Psychiatric care/emotional problems
Y N Rheumatic fever
Y N Immune System Disorders (AIDS, HIV, ARC)
Y N Sinus problems
Y N Physical or mental handicap
Y N Thyroid disorders
Y N Eye disorders
Y N Tonsilitis
Y N Ulcer or Colitis
Y N Extreme nervousness or apprehension
Y N Other _____

Describe any current medical treatment including drugs taken, even though not listed above _____

_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are responsible for payment of fees. We will prepare necessary forms or reports to help the persons responsible to obtain benefits from insurance companies, upon receipt of full (or partial) payment of bills. We do not render our services on the basis that insurance companies we pay at of our fees. Each fee is individual to the individual patient.

I HAVE RECEIVED A COPY OF THE PRIVACY POLICIES.

Signature of Parent/Legal Guardian _____ Date _____