SMILE EXPLORERS
PEDIATRIC DENTISTRY

Patient Health History

Child's Full Name: _____ Nickname: _____ Date:_____
Date of Birth:____/_____/_____ Gender: ❑ M ❑ F Weight:_____lbs. Date of last physical examination:_____

Name/address/phone of primary physician:_____

Name/address/phone of medical specialists: _____

Is your child taking any medications, vitamins, supplements?..... ❑ YES ❑ NO
List name, dose, frequency & date started: _____
Has your child ever been hospitalized or had surgery?..... ❑ YES ❑ NO
List date & describe: _____
Has your child ever had a reaction or allergy to anesthetic, sedative, an antibiotic, or any other medication?..... ❑ YES ❑ NO
Is your child allergic to latex or any other materials or dye? List: _____ ❑ YES ❑ NO

Please mark YES if your child has a history of any of the following conditions. For each "YES", provide details in the box as the bottom of this list. Mark NO if the condition does not apply to your child.

Complications before or during birth, prematurity, birth defect, syndromes, or inherited conditions..... ❑ YES ❑ NO
Problems with physical growth or development..... ❑ YES ❑ NO
Congenital heart defects/disease, heart murmur, rheumatic fever, rheumatic heart disease..... ❑ YES ❑ NO
Asthma, reactive airway disease, breathing problems..... ❑ YES ❑ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions..... ❑ YES ❑ NO
Rash/ hives, eczema or skin problems..... ❑ YES ❑ NO
Impaired vision, hearing, speech..... ❑ YES ❑ NO
Developmental disorders, learning problems/delays..... ❑ YES ❑ NO
Cerebral palsy, brain injury, epilepsy, or convulsions/ seizures..... ❑ YES ❑ NO
Autism/autism spectrum disorder..... ❑ YES ❑ NO
ADD or ADHD..... ❑ YES ❑ NO
Behavioral, emotional, communication, or psychiatric problems/treatment..... ❑ YES ❑ NO
Diabetes..... ❑ YES ❑ NO
Thyroid or pituitary problems..... ❑ YES ❑ NO
Anemia, sickle cell disease/trait, or blood disorder..... ❑ YES ❑ NO
Hemophilia, easy bruising, or excess bleeding..... ❑ YES ❑ NO
Cancer, tumor, chemotherapy, radiation therapy..... ❑ YES ❑ NO

Provide details here:

_____

By signing I affirm that all the information given is to my best knowledge. It will be held in the strictest confidence and I understand it is my responsibility to inform the office of any changes regarding my child's health history.

Signature: _____ Date: _____

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PATIENT INFORMATION

PATIENT LAST NAME FIRST NAME MI

ADDRESS

CITY STATE ZIP

DOB AGE M ☐ F ☐ EMAIL

MOBILE # HOME#

PARENT/ GUARDIAN INFORMATION

WHO BROUGHT THE PATIENT IN TODAY? NAME RELATIONSHIP

DO YOU HAVE LEGAL CUSTODY OF THIS PATIENT? YES ☐ NO ☐

EMERGENCY CONTACT: NAME/NUMBER RELATIONSHIP

MOTHER'S NAME MOTHER'S DOB

ADDRESS (IF DIFFERENT FROM ABOVE)

MOTHER'S CELL # MOTHER'S WORK #

MOTHER'S EMAIL MOTHER'S EMPLOYER

FATHER'S NAME FATHER'S DOB

FATHER'S ADDRESS (IF DIFFERENT FROM ABOVE)

FATHER'S CELL PHONE # FATHER'S WORK PHONE #

FATHER'S EMAIL FATHER'S EMPLOYER

DENTAL HISTORY

What is your primary concern about your child's oral health? _____

Does your child have a history of the following? For each YES response, please describe:

Mouth sores or fever blisters	☐YES ☐ NO	_____
Bad breath	☐YES ☐ NO	_____
Bleeding gums	☐YES ☐ NO	_____
Cavities/ decayed teeth	☐YES ☐ NO	_____
Toothache	☐YES ☐ NO	_____
Injury to teeth, mouth or jaw	☐YES ☐ NO	_____
Clinching, grinding his/her teeth	☐YES ☐ NO	_____
Excessive gagging	☐YES ☐ NO	_____
Sucking habit after one year of age	☐YES ☐ NO	_____

Has your child been examined or treated by another dentist? ☐YES ☐ NO

If YES: Date of first visit: _____ Date of last visit: _____

Has your child ever had a difficult visit at the dentist? ☐YES ☐ NO

If YES, describe: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involves in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)

I have also been informed of and given the right to review a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my information is used and disclosed to carry out treatment or pay the health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date:_____

Print Patient Name:_____

Signature:_____

Relationship to Patient:_____