JUST KIDZ DENTISTRY PC

Health History Form

We are delighted to have you as a new patient. May we extend our sincere thanks for the opportunity to meet your child's dental needs. We look forward to a continued relationship with you!

WELCOME TO OUR PRACTICE!

1 Tell Us About Your Child

Child's Name _____

Nickname_____

★ Male ★ Female

Birthdate_____Age_____

Mobile/Home #_____

SS#_____

Home Address_____

_____

_____

2 Parent 1- Information

Name _____

Birthdate_____

Employer_____

M#_____ H#_____Othr# _____

SS#_____

3 Parent 2- Information

Name _____

Birthdate_____

Employer_____

M#_____ H#_____Othr# _____

SS#_____

4 Who is Accompanying the Child…

Name _____

Relationship _____

Do you have legal custody of this child?

★ Yes ★ No

5 Person Responsible for Account

Name _____

Relationship_____

Billing Address_____

_____

M#_____ H#_____ Othr# _____

E-mail_____

6 Primary Dental Insurance

Ins. Co. Name_____

Address_____

_____

Ins. Co. Phone#_____

Group #_____

Policy Owner's Name_____

SS# or ID# _____

Policy Owner's Employer _____

7 Secondary Dental Insurance

Ins. Co. Name_____

Address_____

_____

Ins. Co. Phone#_____

Group #_____

Policy Owner's Name_____

SS# or ID# _____

Policy Owner's Employer _____

_____

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

8 Dental History

Is this your child's first visit to the dentist? _____
If not, how long since the last dental exam? _____
Were x-rays taken at previous dental visit? _____
Was a teeth cleaning done at previous dental visit? _____
Have there been any injuries to the teeth,
face or mouth? ★ Yes ★ No
If yes, please explain: _____

_____

Why did you bring your 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 Finger habit

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 any fluoride supplements? ★ Yes ★ No
Has the child ever had any pain or tenderness
in his/her jaw? _____
Does the child brush his/her teeth daily? ★ Yes ★ No
Floss his/her teeth daily? ★ Yes ★ No

Has anyone in your immediate family ever had a reaction
when using Nitrous Oxide? ★ Yes ★ No

9 Health History

Has the child ever had any of the following?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Disease
Y N Convulsions/Epilepsy
Y N Rheumatic/Scarlet Fever
Y N Frequent ear infections
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV/AIDS
Y N Kidney/Liver Problems
Y N ADD/ADHD
Y N Allergies to Latex
Y N Autism

Please discuss any serious medical problems the
child has had_____

_____

_____

Please list all the drugs the child is taking:

_____

Please list all allergies:

_____

Is the child currently under the care of a
Physician other than a well child visit? Yes No

Child's Physician _____

Phone #_____

Please describe the child's current physical health

★ Good ★ Fair ★ Poor

10

Tell us how you heard about Just Kidz Dentistry:

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest 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.

Printed Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

Date: _____

Relationship to Patient: _____

Email & Text Appointment Reminders!- We invite you to participate in our online system.

Email: _____ Email Opt OUT ☐ Parent/Guardian Initial _____

Mobile:_____ Text Opt OUT ☐ Parent/Guardian Initial _____

"We're in this together!"