DENTAL AND MEDICAL HISTORY **HOW DID YOU HEAR ABOUT US?** _____

CHILD'S NAME: _____ **DATE OF BIRTH:** _____ ☐ **MALE** ☐ **FEMALE**

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING:

☐ **NURSING/BOTTLE HABITS** ☐ **THUMB/FINGER SUCKING** ☐ **DENTAL GRINDING** ☐ **PACIFIER**

Child's physician name: _____ **Phone:** _____

Is the child currently taking any medications? **Y** ☐ **N** ☐ **If yes, what?** _____

Is the child allergic to any of the following medications or substances? **Y** ☐ **N** ☐

☐ **Aspirin** ☐ **Penicillin** ☐ **Latex** ☐ **Foods** ☐ **Metals/Acrylics** ☐ **Other:** _____

PLEASE ANSWER ALL FOLLOWING QUESTIONS:

AIDS/HIV	**Y__N__**	**Drug/Alcohol Use**	**Y__N__**	**Allergies**	**Y__N__**
Anemia	**Y__N__**	**Fainting/ Dizziness**	**Y__N__**	**Prosthetic Joints/Pins**	**Y__N__**
Asthma/Breathing Problems	**Y__N__**	**Hepatitis**	**Y__N__**	**Liver Disease**	**Y__N__**
Autism	**Y__N__**	**Heart Murmur**	**Y__N__**	**Tobacco Use**	**Y__N__**
Arthritis	**Y__N__**	**Kidney Disease**	**Y__N__**	**Pregnancy**	**Y__N__**
ADHD(Attention Deficit Hyperactivity Disorder)	**Y__N__**	**Leukemia**	**Y__N__**	**Ulcers**	**Y__N__**
Birth Defects	**Y__N__**	**Sickle Cell Anemia**	**Y__N__**	**Diabetes**	**Y__N__**
Bleeding/Clotting Problems	**Y__N__**	**Tuberculosis**	**Y__N__**	**Speech/Hearing Problems**	**Y__N__**
Chronic Adenoid/ Tonsil Problems	**Y__N__**	**Disabilities/ Special Needs**	**Y__N__**	**Convulsions/Seizures**	**Y__N__**
Other:	**Y__N__**			**PRE-MED:** **HEART SURGERY:**	**Y__N__** **Y__N__**

If you answered "Y" to any of the above, please explain: _____

Parent/Guardian Signature: _____ **Date:** _____ **PHONE:** _____
Parent/Guardian Signature: _____ **Date:** _____ **PHONE:** _____
Parent/Guardian Signature: _____ **Date:** _____ **PHONE:** _____
Parent/Guardian Signature: _____ **Date:** _____ **PHONE:** _____
Parent/Guardian Signature: _____ **Date:** _____ **PHONE:** _____
Parent/Guardian Signature: _____ **Date:** _____ **PHONE:** _____

ACKNOWLEDGEMENT OF NOTICE PATIENT PRACTICES (HIPPA)

I acknowledge that I have read in it's entirety the "Patient Practice Privacy Policies" of CDHC,PC/Kids Dental, PC and am aware that I may obtain a copy of the policy upon request.

_____ _____ _____
Parent/Guardian Signature **DATE** _____
Other Authorized Parties

INSURANCE: Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits. You agree to pay any portion of the charges not covered by insurance. I hereby authorize payment by my dental insurance company be directly made to Children's Dental Health Center, PC/Kids Dental, PC. I also authorize the release of any dental information necessary to process all dental claims. I understand that I am ultimately responsible for all costs of dental treatment provided for me/my family regardless of insurance coverage.

_____ _____ _____
Parent/guardian Signature **Relationship to Patient** **DATE**