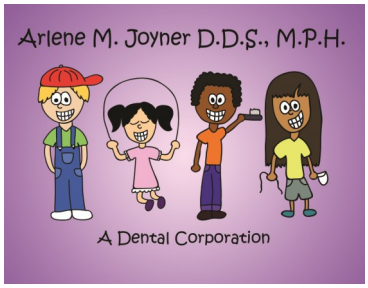
Welcome



13412 Inglewood Avenue
Hawthorne, CA 90250
Phone: 310 219-3266
FAX: 310 219-3268

Health History Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the patient is responsible for payment at the time of service.

1. Tell Us About The Patient

Patient's Name

_____
Last First MI

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat _____

Patient's Birthdate _____/_____/_____ Patient's Age _____

School_____Grade_____

Patient's Home # (_____) _____

SS#_____

Patient's Home Address:_____

_____
City State Zip

Email Address:_____

2. Who may we thank for referring you to our office?

_____

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

5. Who is Accompanying the Patient Today?

Name _____

Relationship_____

Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

_____
City State Zip

Home # (_____)_____

Work # (_____)_____

Cellular # (_____)_____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

9. Dental History

Is this the patient's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain_____

_____

_____

Why did you bring the patient to the dentist today? _____

_____

_____

Does the patient have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the patient ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the patient's water fluoridated? Yes No

Is the patient taking fluoride supplements? Yes No

Has the patient ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? Yes No

Does the patient brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the patient ever had any of the following conditions?

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 Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD

Y N Disabilities/Special Needs
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Autism

Please discuss any serious medical conditions the patient has had

_____

_____

Please list all drugs the patient is currently taking_____

_____

Please list all allergies_____

_____

Patient's Physician _____

Phone (_____)_____

Is the patient currently under the care of a physician? Yes No

Please describe the patient's current physical health...

Good **Fair** **Poor**

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

11.

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

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____