Arlene J. Coloma, D.D.S., M.S.
Pediatric Dentistry

Patient Health History Update

Name Age

****PLEASE ALERT US TO ANY HEALTH CHANGES YOUR CHILD MAY HAVE EXPERIENCED SINCE YOUR LAST VISIT WITH US.**

1. Is there any medication your child is currently taking? If so, for what reason?
2. Are there any allergies?
3. Has your child been hospitalized recently? If yes, for what reason?
4. Does your child have any history of Heart Murmur or any condition that would require pre-medication prior to dental treatment (i. e. shunts, prosthetics)
5. When was your child's last medical check up?

Your doctors name and phone

6. Do you have any particular concerns regarding your child's dental health that you wish to discuss with the doctor?

Visit Date Parent/Guardian sign

Doctor reviewed

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WELCOME!

Tell Us About Your Child: Date:

Child's Name: Sex: M F Age:

Nickname: Birth date: SS# Home Phone #:

Address:

School: Hobbies/Interests:

Who Is Accompanying The Child Today?

The Parent/Guardian who accompanies the child is responsible for payment at time of service.

Name: Relation:

Do you have legal custody of the child? Yes No Is the child adopted? Yes No

Is the child living in a foster home? Yes No

Who may we thank for referring you? Other siblings seen by us:

Parent's Information:

Mother Stepmother Guardian

Name: SS# Birth date: DL#

Address: Home #

Employer: Work#

Father Stepfather Guardian

Name: SS# Birth date: DL#

Address: Home#

Employer: Work#

Person Responsible For Account:

Name: Relation SS# DL#

Address Home #

Employer: Work#

Person Responsible For Making Appointments:

Name: **Home#** **Work#**

Primary Dental Insurance

Insurance company Name:

Ins. Address:

Ins. Phone#: Group#

Policy owner's Name:

Relation to patient:

Policy owners birth date: SS#

Policy owners employer:

Employer's address:

Orthodontic Coverage? Yes No

Secondary Dental Insurance

Ins. Company Name:

Ins. Address:

Ins. Phone#: Group#

Policy owner's Name:

Relation to patient:

wners birth date: SS#

Policy owners employer:

Employer's address:

Orthodontic Coverage? Yes No

Dental History

Why did you bring your child to the dentist today?

Has your child ever had a serious/difficult problem associated with previous dental work? Yes No

Is your child's water fluoridated? Yes No Is your child taking fluoride supplements? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ)? Yes No

Has anyone in your child's family had missing or extra teeth? Yes No If yes, who?

Rate your child's dental health: Excellent Good Fair Poor

Child's age when first tooth appeared/erupted?

Does/did your child have any of the following habits? Lip sucking/biting Yes No Nail biting Yes No

Nursing bottle habits Yes No Thumb/Finger sucking Yes No

Grinding teeth Yes No Pacifier Yes No

Was/Is your child breast fed? Yes No Until what age was your child breast fed?

If a bottle was used, when was it discontinued?

Previous/Present dentist: **Last visit date:**

Were x-rays taken? Yes No

Does your child brush their teeth daily? Yes No Does your child floss daily? Yes No

Medical History

Child's Physician: **Phone#**

Address:

Is your child currently under the care of a physician? Yes No If yes, explain

Please describe your child's current physical condition Good Fair Poor

Are immunizations current? Yes No

Please list all drugs that your child is currently taking:

Please list all drugs and/or other things that your child is allergic to (including food and environmental):

Is your child latex sensitive? Yes No Is your child allergic to any metals? Yes No If yes, list:

Has your child had/experienced any of the following? Indicate with a check mark:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Mumps
☐	☐	Accidents	☐	☐	Chicken Pox	☐	☐	Hepatitis	☐	☐	Patent Ductus Arteriosus
☐	☐	AIDS/HIV positive	☐	☐	Congenital Birth Defect	☐	☐	Herpes	☐	☐	Psychiatric Treatment
☐	☐	Anemia	☐	☐	Congenital Heart Defect	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever
☐	☐	Any Hospital Stays	☐	☐	Convulsions	☐	☐	Hives	☐	☐	Scarlet Fever
☐	☐	Any Operations	☐	☐	Developmental Delays	☐	☐	Jaundice	☐	☐	Seizures
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Joint Replacements	☐	☐	Shunts
☐	☐	Asberger's Syndrome	☐	☐	Epilepsy			(Pins, Rods, Implants)	☐	☐	Significant Injuries
☐	☐	Asthma	☐	☐	Endocrine System Prob.	☐	☐	Kidney Problems	☐	☐	Sickle Cell Anemia
☐	☐	Autism	☐	☐	Exposed to HIV,but negative	☐	☐	Liver Problems	☐	☐	Skin Rash
☐	☐	Behavioral/learning Prob.	☐	☐	Fainting Spells	☐	☐	Low Blood Pressure	☐	☐	Tonsillitis
☐	☐	Blood Transfusion	☐	☐	Frequent Infections	☐	☐	Lupus	☐	☐	Tuberculosis (TB)
☐	☐	Blood Disorder	☐	☐	Handicaps/Disabilities	☐	☐	Measles	☐	☐	Typhoid Fever
☐	☐	Broken Bones/Fractures	☐	☐	Hearing Impairments	☐	☐	Mitral valve Prolapse	☐	☐	Vision Problems
			☐	☐	Heart Murmur	☐	☐	Mononucleosis	☐	☐	Ventral Septal Defect (VSD)

If you answered yes to any of the above, please explain:

your child has any other health problem not listed above please list and explain:

I affirm that the information I have given is correct to the best of my knowledge. 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: Date

I certify that my child is covered by Insurance Co. and I assign directly to Dr. A. Coloma all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also for paying any deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic. Signature: Date:

Office use: I have verbally reviewed the medical/dental information above with the parent/guardian. Initials:

Doctor's Comments: **Date:**

Print Submit Reset