My Home Dental

MEDICAL HISTORY

DENTAL HISTORY

1. **Child's Name:** ______
2. Reason for today's visit: ______
3. Former Dentist ______ 4. City / State ______
5. Date of Last dental visit ______
6. Has your child had an unfavorable experience in a previous dental(medical) office? ______
7. Have there been any injuries to your child's teeth or jaws? ______
8. Does your child receive fluoride vitamins, tablets, water, etc.? ______
9. Has an orthodontist seen your child? If so, Who? ______

CHILD'S HABITS

10. Does your child:
- Suck his / her Thumb / Finger / Lips/ Pacifier ______ YES NO
- Bite / Chew his / her nails or hard objects ______ YES NO
- Grind his / her teeth ______ YES NO

MEDICAL HISTORY

11. **Physician's Name:** ______ Date of last visit ______ Phone#: ______

13. Is your child currently under the care of a physician for any medical problem or condition? YES ☐ NO ☐

If so, please describe ______

14. Is your child currently taking any medicine / allergic to any medication ? YES ☐ NO ☐

Please list name and dosage ______

15. Has your child ever been hospitalized or had surgery? YES ☐ NO ☐

Please describe(for what condition and when) ______

17. Has your child ever had any of the following?

YES	NO		YES	NO	
☐	☐	**Asthma**	☐	☐	**Liver Disorder**
☐	☐	**Cancer**	☐	☐	**Kidney Disorder**
☐	☐	**Hepatitis**	☐	☐	**Gastrointestinal Disorder**
☐	☐	**Hemophilia / Blood**	☐	☐	**Diabetes**
☐	☐	**Rheumatic Fever**	☐	☐	**Congenital Heart Defect**
☐	☐	**Allergies**	☐	☐	**Heart Murmur**
☐	☐	**Epilepsy or Seizures**	☐	☐	**Anemia**
☐	☐	**Tuberculosis**	☐	☐	**Red Dye Allergy**
☐	☐	**ADD / ADHC**	☐	☐	**Latex Allergy**

Was your child born prematurely? By how long?: ______

Is your child developmentally delayed, physically handicapped, or have any learning or emotional disabilities? ______

Please describe any other medical history or problems you feel should be brought to the doctor's attention: ______

Please list your child's allergies to any medications or foods: ______

I HEREBY AUTHORIZE DR. MIN C. DO / DR. HELEN H. DO / HANNAH SONG TO PERFORM A DENTAL EXAMINATION INCLUDING DENTAL X-RAYS, IF NECESSARY, FOR MY ABOVE NAMED CHILD. ANY ADDITIONAL PROCEDURES BEYOND A DENTAL CLEANING WILL BE EXPLAIN

Signature of patient or parent of minor ______ Date ______ **Dentist's Signature** ______ Date ______

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Parent Signature

PATIENT INFORMATION

Has any member of your family been a patient of our office? Yes / No Name of Siblings:________________

Date:________________________ ____________

Patient Name:____ Patient **Social Security** #:________________

Address:____ Tel (C):____________

City:_______________________________________ State: ____________ Zip: _______________ Tel (H):____________

Birthday: ______/______/_________/ Age:_________ Sex: Male/Female

Parent Employed By:____ Parent Occupation:________________

Business Address:____

City:____ State: ____________ Zip: _______________ Tel:____________

Who is responsible for this account?____________________________________ Relationship to Patient: ______________

Who should we contact in an emergency?____ Phone:______________

DENTAL INSURANCE INFORMATION

Dental Insurance Primary Carrier	Dental Insurance Secondary Carrier
Insured's Name: Social Security #:	Insured's Name: Social Security #:
Insurance Company:	Insurance Company:
Address:	Address:
Group Number: ID Number: Birthday:	Group Number: ID Number: Birthday:
Insured's Employer:	Insured's Employer:

What problems would you like to discuss with the doctor and how may we help you?______________________________

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How did you hear of our office?____

CHARGES AND PAYMENTS: Charges will be explained and agreed prior to dental treatment. Payment is payable **at the time services** are rendered. There is a **charge for broken appointments**. Failure to keep a reservation and/or failure to give the office more

Thank you for your cooperation and for selecting our dental office. We will do our best to make your visits as caring as possible.