HEALTH HISTORY & INFORMATION

Patient's Full Name____ Nickname, if any____________________________

Age____________ Birthdate________________ Male__________________________ Female__________________________

Name & age of brothers & sisters____

Physician or Pediatrician____

How did you find out about our office?____

____

MEDICAL HISTORY

Has the patient had any of the following? (Please circle those that apply. If none apply, so state at the bottom)

AIDS	Chronic Illness	Hospitalization	Scarlet Fever
Allergies	Convulsions	Kidney Disease	Sickle cell disease
Asthma	Diabetes	Leukemia	Surgery of any kind
Behavioral problems	Epilepsy-seizures	Liver Disease	Tuberculosis
Bleeding problems	Heart problems	Pneumonia	Tumors-cancer
Birth defects	Heart surgery	Pregnant	Other_________________
Cerebral palsy	Hemophilia	Premature birth	_____________________
Chronic ear infections	Hepatitus	Rheumatic fever	**NONE OF THESE APPLY**

Please explain any of the above that are circled or any other health problems_______________________________________

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DENTAL HISTORY

		NO	YES
1.	Has the patient had any unfavorable reaction to any medications? If yes, list names of medications____	____	____
2.	Is the patient allergic to penicillin?	____	____
3.	Has your child had any history of thumb sucking, tongue thrusting, mouth breathing, vomiting?	____	____
4.	Has the patient had any unfavorable experience in a dental or medical office? (If so, please explain)	____	____
5.	Is the patient taking any medicine?____	____	____
6.	Has the patient had a toothache or pain recently?_______________________________________	____	____
7.	Give date of last dental care________________________previous dentist________________		
8.	What things concern you about your child's teeth?____________________________________ ____ ____		

Signature of person giving this history____Date____________________

Relationship to patient____

Reviewed by:____

PLEASE COMPLETE REVERSE SIDE

PARENTAL INFORMATION

Mother/Guardian's Full Name____Soc Sec No________________________

Residential Address ____
Street Apt City State Zip

Mailing Address ____
Street Apt City State Zip

DOB__________________Occupation_______________________Emp____
If self-employed, please state business name

Work Address ____Driver License No. _____________________

Home Phone_____________________Work Phone___________________Cell___________________________________

Email____

Father/Guardian's Full Name____Soc Sec No________________________

Residential Address ____
Street Apt City State Zip

Mailing Address ____
Street Apt City State Zip

DOB__________________Occupation_______________________Emp____
If self-employed, please state business name

Work Address ____Driver License No. _____________________

Home Phone_____________________Work Phone___________________Cell___________________________________

Email____

FINANCIAL AGREEMENTS

Payment is required for services rendered at the time of that treatment.

Method of Payment: ☐ Cash ☐ Check ☐ Credit Card (Master Card or Visa)

Is patient covered by dental insurance? (Circle one) YES NO

If yes,____________________________ __________________ ____
Name of insurance company Group policy no. Covered patient's name

The policy of our office is that the parent who brings the child for treatment is responsible for all fees for treatment rendered.

Financial Agreement:
I understand that I am responsible for the payment of all fees for dental treatment for the patient named on the reverse side. I understand that I am responsible for any fee not paid by the patient's dental insurance. The undersigned agrees: should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

____ ____
Print Name Date

____ ____
Signature Relationship to patient

PERMISSION FOR TREATMENT UPON A MINOR

I, being the parent or guardian of the named minor patient, do hereby authorize and request the performance of a dental examination, (to include x-rays deemed necessary by the dentist to properly arrive at a diagnosis and treatment plan), teeth cleaning, fluoride treatment, and the application of pit and fissure sealants (plastic coatings) to the grooves of teeth for this patient. I understand that I will be informed of all services by Dr. Evershed before any of the services are rendered for my child. I understand that I have the right to decline to accept any of the recommended treatment once the treatment plan is explained to me.

Date___________________________ Signed____

Child's Name____Relationship_______________________

Witness____