200 Elm Street
Pittsfield, MA
PH: (413) 499-4850

100 Maple Ave
Great Barrington, MA
PH: (413) 528-4490

Health History Form

NOTE: The Parent or Guardian who accompanies the child is responsible for payments at the time of service.

Today's Date: _____

1. Tell Us About Your Child

Child's Name_____
MALE _____ or FEMALE _____

Child's Birthdate _____/_____/_____

Child's Age _____

2. Parent Information

Name_____

Parent or Guardian

Birthdate _____/_____/_____

Employer _____

Cell Phone # (_____)_____
Home # (_____)_____
SS# _____ DL#_____

3. Parent Information

Name_____

Parent or Guardian

Birthdate _____/_____/_____

Employer_____

Cell Phone # (_____)_____
Home # (_____)_____
SS # _____ DL # _____

4. Who is Accompanying the Child Today?

Name_____

Relationship _____
Do you have legal custody of this child?
Y___N___

5. Person Responsible for Account

Name_____

Relationship _____

Billing Address _____

_____

Cell Phone # (____)_____
Home # (____)_____

E-Mail _____

6. Primary Dental Insurance

Insurance Co.Name_____

Insurance Co. Address _____

_____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Holder's Birthdate _____/_____/_____

SS# _____ Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (____)_____

Policy Holder Birthdate _____/_____/_____

SS# _____ Employer _____

8. Dental History

Is this your child's first visit to the dentist _____

When was your child's last dental appt_____

Previous Dentist's name_____

Were any x-rays taken at previous dental visits _____

Any injuries to the teeth, face, or mouth? Explain

_____

_____

What is your child seeing the dentist for_____

_____

Does your child have any of the following habits?

Lip Sucking/Biting_____ Nail Biting_____

Nursing/Bottle Habits____ Thumb/Finger Sucking____

Has the child ever had a serious or difficult problem with previous dental work? Explain

_____

_____

Is the child's water fluoridated_____

Is the child taking fluoride supplements_____

Has the child ever had TMJ/TMD joint pain_____

Does the child brush daily_____ Floss_____

Do you assist w/brushing & flossing_____

9. Health History

Has the child ever had any of the following conditions?

Abnormal Bleeding_____ Hearing Impairments_____

Allergies to Drugs_____ Heart Disease/Murmur_____

Hospital Stays_____ Allergies to Latex Products____

Operations_____ Disabilities/Special Needs_____

Asthma_____ Kidney/Liver Conditions_____

Cancer_____ Rheumatic/Scarlet Fever_____

Congenital Birth Defects_____ Hepatitis_____

Pregnancy_____ HIV+/AIDS_____

Tuberculosis_____ Diabetes_____

ADD/ADHD_____ Autism_____

Any serious medical conditions the child has had?

_____

_____

Any medication the child is currently taking?

_____

Any allergies? _____

Child's Physician_____

Physician's Phone # (____)_____

Is there anything about the color, shape or position of the child's teeth you would like to discuss?

_____

10.

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 the office of any changes in the child's medical status. **I authorize the dental staff to perform the necessary dental services my child may need.**

_____

Signature of Parent/Guardian

_____

Date Relationship to Patient

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

_____

I verbally reviewed the medical/dental information above with the parent/guardian & patient named

Initials_____ **Date**_____

Doctor's Comments_____

_____

_____