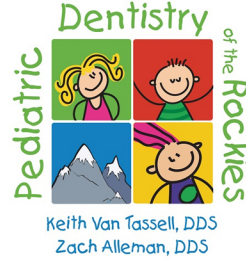


Welcome



4609 South Timberline Rd., Suite 103B
Fort Collins, CO 80528
PH: (970) 484-4104
FX: (970) 484-5245

Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office.
The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
First Last MI

Nickname _____ Male Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

Child's Home # (_____) _____

SS# _____

Child's Home Address: _____

City State Zip

2. How did you find our practice?

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

5. Who is Accompanying the Child 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

Cellular# (_____) _____

Work # (_____) _____

E-mail _____

Other Contact Information _____

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 child's first visit to the dentist? _____ If

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

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 child to the dentist today? _____

Does the child 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 child ever had a serious or difficult problem associated with previous dental work? **Yes** **No**

If yes, please explain _____

Is the child's water fluoridated? **Yes** **No**

Is the child taking fluoride supplements? **Yes** **No**

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

Does the child brush his/her teeth daily? **Yes** **No**

Floss his / her teeth daily? **Yes** **No**

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding Y N Handicaps/Disabilities

Y N Allergies to any Drugs Y N Hearing Impairment

Y N Any Hospital Stays Y N Heart Disease/Murmur

Y N Any Operations Y N Hemophilia/Blood Disorders

Y N Asthma Y N Hepatitis

Y N Cancer Y N HIV + / AIDS

Y N Congenital Birth Defects Y N Kidney/Liver Conditions

Y N Convulsions/Epilepsy Y N Rheumatic/Scarlet Fever

Y N Pregnancy Y N Allergies to Latex Product

Y N Tuberculosis Y N Diabetes

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all drugs the child is allergic to _____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? **Yes** **No**

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

Good **Fair** **Poor**

11. Authorization to Accompany Minor Child

I authorize the following individuals to bring my child in for dental treatment and check ups while I am not present.

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

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 _____ Relationship to child _____ Date _____

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