Welcome

Health History Form

Pediatric Dentistry of the Rockies
Keith Van Tassell, DDS
Zach Alleman, DDS

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

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 Stepfather 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 Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
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.