Dr. Ashley Ramsey
9101 Lakeview Parkway, Suite 200
Rowlett, Texas 75088
Ph: 972-412-5064 Fax: 972-412-5076
www.mykidzdental.com

HEALTH HISTORY FORM

Please **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.

Tell Us About Your Child

Child's Name ______________________________
Last First MI.

Nickname ____________ O Male O Female

Siblings that we treat ______________________

Child's Birth Date ____/____/____ Child's Age __________

Child's Home # (_____)__________ SS # ____________

Child's Home Address ______________________

____
City State Zip

Who May We Thank for Referring You to Our Office?

____

____

Mother's Information

Name ______________ Birth Date ____/____/____

O Mother O Stepmother O Guardian

Employer ______________________

Work # (______) ____________ Ext. ________

Home # (______) __________ Cell # (_____) ________

SS # ______________ DL # ______________

Father's Information

Name ______________ Birth Date ____/____/____

O Father O Stepfather O Guardian

Employer ______________________

Work # (______) ____________ Ext. ________

Home # (______) __________ Cell # (_____) ________

SS # ______________ DL # ______________

Who is Accompanying the Child Today?

Name ______________________

Relationship ______________________

Do you have legal custody of this child? O Yes O No

Person Responsible for Account

Name ______________________

Relationship ______________________

Billing Address ______________________

____
City State Zip

Home # (_____) __________ Work # (_____) __________

Cell # (________) ______________

E-mail ______________________

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 Birth Date ___/___/___ SS # __________

Policy Owner's Employer ______________________

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 Birth Date ___/___/___ SS # __________

Policy Owner's Employer ______________________

-OVER-

PATIENT DENTAL HISTORY

Please answer the following questions:

Has your child been to any dental office in the last six months? O Yes O No

If yes, what was the dentist's name? ______________________

If yes, when was the visit and what was done? ______________________

Has your child ever had dental X-rays? O Yes O No If yes, when? ______________________

Has your child ever had problems with dental anesthetics? O Yes O No If yes, explain: ______________________

Do you expect your child to be a cooperative dental patient? O Yes O No If no, explain: ______________________

Please rate you child's comfort level with receiving dental treatment: Comments: ______________________

O Unknown O No Problem O Slightly Anxious O Moderately Anxious O Fearful

Please note any problems that your child has had with past dental experiences: ______________________

Reason for visit:

O Routine Visit O Cosmetic O Habit O Orthodontic O Emergency

O Behavior O Decay O Physical or Mental Handicap O Other: ______________________

Please answer the following questions:

Does your child have or has he/she had any of the following?

O Thumb Sucking	How Long?	______________	Still active?	O Yes	O No
O Finger Habit	How Long?	______________	Still active?	O Yes	O No
O Pacifier	How Long?	______________	Still Active?	O Yes	O No
O Dental Trauma	Explain:	______________			

Does your child clench or grind their teeth?	O Yes	O No	If yes explain:	______________
Are you pleased with the appearance of your child's smile?	O Yes	O No	If no explain:	______________
Does your child sleep with a bottle at night?	O Yes	O No	If yes explain:	______________
Does your child's bottle or sippy cup contain fluid other than milk or water?	O Yes	O No	If yes explain:	______________

PREVENTIVE

How often does your child brush? ______________________

Is tooth brushing and flossing supervised? O Yes O No By whom? ______________________

Does your child receive: O Fluoridated water (city or county)

O Bottled water

O Well water

O Fluoride in vitamins

O Fluoride in tablets/drops

PATIENT MEDICAL HISTORY

Is your child presently under the care of a: O Pediatrician **or** O Family Physician

For specific medical reason? O Yes O No If yes, explain: ______

Physician's Name: ______ Phone Number: ______

Is your child in good health? O Yes O No If no, explain: ______

Is your child taking any medications at this time? O Yes O No If yes, list: ______

Has your child ever been hospitalized or treated in an emergency room for trauma? O Yes O No

If yes, when and for what reason? ______

a. Does your child have any of these conditions? O Heart Murmur O Pins O Plates O None

b. If so, has your child been instructed to be pre-medicated for this or other condition? O Yes O No

Does your child have, or has he/she had, any emotional, mental or nervous disorders? O Yes O No

If yes, please explain: ______

Has your child's tonsils and/or adenoids been removed? O Yes O No

PLEASE INDICATE IF YOUR CHILD HAS/HAD ANY OF THE FOLLOWING:

O Allergy to Penicillin
O Other drug allergy
O Allergy to food
O Allergy to latex
O Tobacco/Drug
O Anemia
O Rheumatic fever
O Bone disorder
O Skin disorder (eczema)

O Mental handicap
O Positive for HIV
O Diabetes
O Epilepsy, seizures
O Bleeding disorder
O Tuberculosis
O Autism
O Physical handicap
O Other: ______

O Heart ailment or murmur
O Cleft palate
O Asthma
O Liver problems or hepatitis
O Malignancies or leukemia
O Speech problem
O Behavioral problems
O ADD/ADHD
O Other: ______

Is child under the care of a cardiologist or special physician? O Yes O No

Physician: ______ Office Phone: ______

Comment on any other problems that were checked above: ______

AUTHORIZATION, RELEASE, & AGREEMENT to PAY for SERVICES RENDERED

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatment, X-rays and examinations) before the treatment is performed.

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 change in my child's medical status.

I, the parent or guardian, who accompanies the child, am responsible for payment at the time of service, unless prior arrangements have been approved. I understand that this office files my insurance for me as a courtesy and that I am responsible for all charges whether or not paid by insurance.

Signed (parent or legal guardian): ______ Date: ______

Printed Name: ______ Relationship to Patient: ______

Child's Name ______ Age ______