Child Health History

DR. WEEKS & ASSOCIATES

Child's Name: *LAST* *FIRST* *MIDDLE INITIAL*

Child's Preferred Nickname to be called:

Sex: ☐ M ☐ F

Date of Birth: / /

Social Security #: - -

Mailing Address:

City:

State:

Zip:

Phone #: ( ) –

Who will be responsible for paying this account?

Child's hobbies?

Child's pets (type and name)?

Describe your child's temperament:

How did you hear about us?

☐ Advertisement ☐ Phone Book ☐ Internet ☐ Office Sign ☐ Other: _____

☐ Another patient - Please list their name so we may thank them: _____

Insurance Information

PRIMARY INSURANCE COMPANY: _____	SECONDARY INSURANCE COMPANY: _____
Subscriber Name:	**Subscriber Name:**
Subscriber Social Security #: / /	**Subscriber Social Security #:** / /
Subscriber Date of Birth: - -	**Subscriber Date of Birth:** - -
Employer:	**Employer:**
Group #:	**Group #:**
Member ID #:	**Member ID #:**
Insurance Phone #: ( ) –	**Insurance Phone #:** ( ) –

Father Information

Father's Name: *LAST* *FIRST* *MIDDLE INITIAL*

Social Security #: - -

Mailing Address *(if different than child's address)*:

City:

State:

Zip:

Email Address:

Home Phone: ( ) –

Work Phone: ( ) –

Cell Phone: ( ) –

Mother Information

Mother's Name: *LAST* *FIRST* *MIDDLE INITIAL*

Social Security #: - -

Mailing Address *(if different than child's address)*:

City:

State:

Zip:

Email Address:

Home Phone: ( ) –

Work Phone: ( ) –

Cell Phone: ( ) –

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Dental History

If the child has been to the dentist before, please list reason and date of visit:

/ /

Dentist Name: **Was the experience good or bad?**

Does the child have any oral habits (such as finger sucking, grinding teeth, etc…), if so please describe?

Child's Physician Name and Phone Number:

Health History

Does the child have or ever had any of the following (please check all that apply):

☐ Allergies	☐ Cancer	☐ HIV or AIDS	☐ Orthodontic Treatment
☐ Anemia	☐ Chronic or Congenital Heart Disease	☐ Hospital Admissions	☐ Physical, Mental, or Sensory Development
☐ Asthma	☐ Diabetes or Hypoglycemia	☐ Injury to mouth, head, or neck	☐ Pregnancy (Teens)
☐ Autism / Asperger's	☐ Hearing Problems	☐ Kidney or Bladder Problems	☐ Rheumatic Fever
☐ Bleeding Problems or Disorders	☐ Heart Problems or Murmurs	☐ Liver Problems	☐ Seizures, Epilepsy or Fainting
☐ Blood Disease or Transfusion	☐ Hepatitis	☐ Lung Problems	☐ Tobacco or Drug Use (Teens)

Any disease, condition, or problem not listed above that Dr. Weeks should know about? Please explain:

Has the child ever been advised to take prophylactic antibiotics before dental treatment? ☐ Yes ☐ No

If the child is allergic or has had an unusual reaction to any of the following medications, check any that apply:

☐ Aspirin or Tylenol	☐ Latex	☐ Sedatives or Sleeping Pills
☐ Barbiturates	☐ Local Anesthetic	☐ Sulfa Drugs
☐ Codeine	☐ Metals	☐ Xylocaine
☐ Epinephrine	☐ Nitrous Oxide	☐ Other Antibiotics: _____
☐ Erythromycin	☐ Novocain	☐ Any other drug allergies: _____
☐ Iodine	☐ Penicillin	☐ Any drugs the child has been advised not to take: _____

Please list all the prescription and over the counter medications the child is taking along with the frequency taken.
(Also include vitamins, natural or herbal preparations, and/or diet supplements.)

Because the child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental services and methods can be rendered. I, being the (father, mother, guardian, etc…) of the child, give my consent to the performance of such treatment, service, medication, operations, behavior management techniques, local anesthesia, and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

To the best of my knowledge, all the preceding answers are true and correct. If there are any changes in the child's health or medications, I will inform the doctor at the next appointment. If deemed advisable, I grant permission for the child's physician to be contacted for details and advice. Authorization is also given for dental treatment to be rendered by the dentist and office staff and I will assume financial responsibility. Any account balance 90 days or older will be assessed a finance charge of 18% APR. Any returned checks are subject to a $30.00 fee. In the event it should be necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including collection company and attorney's fees.

Parent / Guardian's Signature: _____ **Date:** _____

Our office is HIPAA compliant and is committed to meeting and exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.