Thai-An Doan, D.D.S.

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Thai–An Doan, DDS
Board Certified Pediatric Dentist
PLANTING THE SEEDS FOR GOOD ORAL HEALTH

Health History Form

For your convenience, bring this completed form with you on your first visit. The parent or Guardian who accompanies the child is responsible for payment at time of service.

Patient

Child's Name: _____
Last First MI
Preferred Name: _____
Gender: _____ Preferred Pronoun: _____
Child's Birthdate: _____ /_____ /_____ Age: _____
SSN: _____-_____-_____
Child's Home Address:
_____
Apt. / Condo #
_____
City State Zip
Primary Phone # (_____) _____-_____
Email: _____
Siblings we also treat: _____

Parent #1

Name:_____
○ Parent/Guardian ○ Step-Parent
Birthdate _____ /_____ /_____ Gender: _____
Cell # (_____) _____-_____
Home # (_____) _____-_____
Work # (_____) _____-_____Ext: _____
Occupation: _____
Employer: _____
SSN: _____-_____-_____

Parent #2

Name:_____
○ Parent/Guardian ○ Step-Parent
Birthdate _____ /_____ /_____ Gender: _____
Cell # (_____) _____-_____
Home # (_____) _____-_____
Work # (_____) _____-_____Ext: _____
Occupation: _____
Employer: _____
SSN: _____-_____-_____

Parent's Marital Status:

○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Who is accompanying the child today?

Name:_____
Relationship: _____
Do you have legal custody of this child? ○ Yes ○ No

Person Responsible for Account

Name:_____
Relationship: _____
Cell # (_____) _____-_____
Billing Address:
_____
Apt. / Condo #
_____
City State Zip

Primary Dental Insurance

Insurance Company:_____
Insurance Co Phone# (_____) _____-_____
Policy Holder's Name: _____
Relationship to Patient: _____
Policy Holder's Birthdate: _____ /_____ /_____
Member ID# _____
SSN: _____-_____-_____
Policy Holder's Employer: _____
Plan Group # _____

Secondary Dental Insurance

Insurance Company:_____
Insurance Co Phone# (_____) _____-_____
Policy Holder's Name: _____
Relationship to Patient: _____
Policy Holder's Birthdate: _____ /_____ /_____
Member ID# _____
SSN: _____-_____-_____
Policy Holder's Employer: _____
Plan Group # _____

Dental History

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

If not, how long has it been since their last visit? _____

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 Thumb/Finger Sucking Y N Nail Biting

Y N Nursing Bottle Habits Y N Lip Sucking/Biting

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 (TMR/TMD)? Yes No

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

Floss his/her teeth daily? Yes No

Health History

Please describe the child's current physical health…

○ Good ○ Fair ○ Poor

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 Murmur
Y N Any Operations	Y N Hemophilia
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N Kidney/Liver Condition
Y N HIV +/ AIDS	Y N Congenital Heart Disease
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex

Y N Autism/Asperger's Syndrome/Sensory Spectrum Disorder

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 _____

_____

Is the child currently under the care of a physician? Y N

Child's Physician _____

Physician's Phone # (_____) _____-_____

Who may we thank for referring you to our office?

_____

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 to my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. I acknowledge that insurance coverage is only an estimation and guarantor is responsible for all treatment not covered.

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only:

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____