Thai-An Doan, D.D.S.

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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 (Nickname): ______________________
Gender: __________ Preferred Pronouns: __________
Child's Birthdate: ____ /____ /_______ Age: _____
SSN: _________-______-____________
Child's Home Address:
____
Apt. / Condo #
____
City State Zip
Primary Phone # (_______) ________-__________
Email: ______________________________________
Siblings we also treat: _________________________

Parent #1

○ Parent/Guardian ○ Step-Parent

Name: ______________________________________
Birthdate: ____ /____ /_______ Gender: __________
Cell # (_______) ________-__________
Home # (_______) ________-__________
Work # (_______) ________-__________Ext: ______
Occupation: _________________________________
Employer: ___________________________________
SSN: _________-______-____________

Parent #2

○ Parent/Guardian ○ Step-Parent

Name: ______________________________________
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? Yes No

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

Were any x-rays taken at previous dental visits? Yes No

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 their jaw/joint (TMR/TMD)? Yes No

Does the child brush their teeth daily? Yes No

Floss their 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 Hemophilia Y N Heart Murmur

Y N Asthma Y N Hepatitis

Y N Cancer Y N Kidney/Liver Condition

Y N Congenital Heart Disease Y N HIV +/ AIDS

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

Any hospital stays or operations? _________________________

____

Please discuss any other serious medical conditions __________

____

____

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 regardless of what is estimated for my dental benefits, my insurance is my responsibility. I understand insurance coverage is only an estimation and guarantor is responsible for all services 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 ______________