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# Health History For Teenage Patients

"State of the Art Dentistry with Hometown Comfort and Caring"

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ School Patient Attends: \_\_\_\_\_

### Please tell us about this Patient

How often does Patient brush their teeth: \_\_\_\_\_ Floss: \_\_\_\_\_ When does Patient brush: \_\_\_\_\_

Has Patient had instructions on the proper way to brush and floss?  Yes  No

Date of last dental visit: \_\_\_\_\_ Does Patient take a fluoride supplement?  Yes  No

Has this Patient had braces or been evaluated for braces?  Yes  No

Does Patient have any fears about visiting the Dentist or Hygienist?  Yes  No

If YES, please explain: \_\_\_\_\_

What Problems or concerns about this Patient's dental health brought you to our office today? \_\_\_\_\_

What does the Patient like about their smile? \_\_\_\_\_

Dislike? \_\_\_\_\_

### FINANCIAL INFORMATION

This Patient lives with:  Mom  Dad  Both Parents  Guardian\* (Relationship) \_\_\_\_\_

Parent/Legal Guardian's Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Parent/Legal Guardian's DOB: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Best phone number to confirm appointments for this Patient: \_\_\_\_\_

Whom should we ask for at the above number? \_\_\_\_\_

\_\_\_\_\_ I understand that it is the responsibility of the person bringing this Patient to treatment to arrange for payment on the day of treatment.

Please Initial \_\_\_\_\_ I understand that a 24-Hour Notice is required to change an appointment. I further understand that there may be a charge for broken appointments if a 24-Hour Notice is not given.

Do you have a dental plan that will reimburse you for a portion of this Patient's dental treatment?  Yes  No  
Yearly Allowance? \_\_\_\_\_

Please Initial \_\_\_\_\_ I understand that dental plans do not cover 100% of dental treatment.

\_\_\_\_\_ I understand that the dental office will upon request notify me of my dependent's estimated portion of my dental treatment and that this amount is due at time of service.

Name of Insured: \_\_\_\_\_ Employer: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_ Insured's SS #: \_\_\_\_\_

\*Documentation required to support Guardianship.



# Health History:

Patient's Physician: \_\_\_\_\_ City \_\_\_\_\_ Last Visit \_\_\_\_\_

Is this Patient currently taking any medication including nonprescription medications or herbal supplements?  Yes  No

If YES, please list all medications: \_\_\_\_\_

Is this Patient allergic to penicillin or any other medications? \_\_\_\_\_

Latex Sensitive?  Yes  No

Female Patients Only: Are you pregnant?  Yes  No      Nursing  Yes  No

Birth control; Do you use pills, patches or shots?  Yes  No

Does Patient have or has had any of the following:

- |  |                         |  |                              |  |                       |
|--|-------------------------|--|------------------------------|--|-----------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High/Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Difficulty    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Surgery   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequently Tired             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting/Seizures       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis/Positive |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Disorder       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema                    |  | TB Test/SCREEN        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Convulsions    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement or         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Diseases         |  | Implant                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma/Respiratory    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or HIV Infection   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis/Jaundice           |  | Problems              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problem         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Troubles/Ulcers      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies -           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitive         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anorexia/Bulimia             |  | Seasonal/Food/Other   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Smoke                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Chew Tobacco            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Use Recreational Drugs       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clicking in Jaw       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clench or Grind Teeth        | Other _____  |                       |

## COMMENTS:

### AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my Dependents health. I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to this Dependent during the period of such Dental care to third party payor and/or health practitioners. \*I agree to be responsible for payment of all services rendered on behalf of this Patient and understand that should this account go into default, I am responsible for all attorney/collection fees up to 40%. My signature below is a consent to provide treatment.

\_\_\_\_\_  
Signature of Parent/Legal Guardian      DATE

\_\_\_\_\_  
Signature of Parent/Legal Guardian      DATE

\_\_\_\_\_  
Changes in Medical History      DATE

\_\_\_\_\_  
Signature of Parent/Legal Guardian      Reviewed By (Initials)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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