CHILD HEALTH HISTORY

Please email completed PDF files to: info@washougalfamilydental.com

Washougal Family Dental

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. Thank you!

1 Patient Information

Today's date: _____

Name: _____

Nickname _____ Male Female

Birthdate: _____ Age: _____

Home Address: _____

_____

School Name: _____ School #: _____

Person Financially Responsible: _____

Hm #:_____ Cell #: _____

Wk #:_____ Ext:____

Whom may we thank for referring you? _____

2 Dental History

Last visit date: _____

For what service? _____

Has child complained about dental pain? Y N

Does child brush teeth daily? Y N

Does child use floss every day? Y N

Is fluoride taken in any form? Y N

Any injuries to mouth, teeth, head? Y N

Any unhappy dental experiences? Y N

If yes, please tell us about it: _____

_____

Any mouth habits –thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? Y N

3 Dental Insurance

Father's / Guardian's Name: _____

Address: (If different from above.) _____

_____

Hm #: _____ Cell #: _____
IF DIFFERENT FROM ABOVE IF DIFFERENT FROM ABOVE

Wk #: _____ Ext:____
IF DIFFERENT FROM ABOVE

E-mail Address: _____

May we send you monthly newsletters via email? Y N

Employer: _____

SS #: _____ Birthdate: _____

Do you have dental insurance coverage for your minor/child?

Y N

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Mother's / Guardian's Name: _____

Address: (If different from above.) _____

_____

Hm #: _____ Cell #: _____
IF DIFFERENT FROM ABOVE IF DIFFERENT FROM ABOVE

Wk #: _____ Ext:____
IF DIFFERENT FROM ABOVE

E-mail Address: _____

May we send you monthly newsletters via email? Y N

Employer: _____

SS #: _____ Birthdate: _____

Do you have dental insurance coverage for your minor/child?

Y N

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Continued on next page.

4 Medical History

Minor/Child's Physician: _____

City/State: _____ Phone #: _____

Date of last physical examination: _____

Results: _____

Is Minor/Child under care of a physician now? Y N

Receiving any medication or drugs? Y N

If yes, please list each one: _____

_____

Ever been hospitalized? Y N

Ever had surgery? Y N

Is there excessive bleeding when cut? Y N

Allergies: _____

_____

Has minor/child had any history of our difficulty with any of the following?

	YES	NO
AIDS/HIV+		
Anemia		
Asthma		
Bladder Problems		
Cancer/Chemotherapy		
Cerebral Palsy		
Chicken Pox		
Convulsions		
Diabetes		
Drug/Alcohol Abuse		
Epilepsy		
Fainting Spells		
Hearing Problems		
Heart Problems		
Hepatitis		
Kidney Problems		
Liver Disease		
Measles		
Mononucleosis		
Mumps		
Rheumatic Fever		
Sinus Problems		
Thyroid Disease		
Tuberculosis		
Other		

5 Emergency Contact

In the event of an emergency, whom should we contact?

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor/child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of

_____

PLEASE PRINT NAME OF MINOR/CHILD

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with

_____

NAME OF INSURANCE COMPANY(IES)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

SIGNATURE OF PARENT/GUARDIAN

DATE

RELATIONSHIP TO PATIENT

If filling out and submitting PDF online:

Typed initials, and first name/last name is sufficient for approval.