Welcome!

Steele Pediatric Dentistry
9602 E. Washington Street Indianapolis, IN 46229
Phone: 317-899-KIDS Fax: 317-897-0771

Health History Form

Today's Date: _____

1. Tell Us About Your Child

Child's Name _____ (Last / First / MI)

Goes by: _____ Gender: _____

Siblings that we treat: _____

Child's Birthdate: ___/___/___ Age: _____

School: _____ Grade: _____

Child's Home # _____

Child's Home Address: _____

_____ (City / State / Zip)

Who does this child live with? _____

2. How Did You Hear About Our Office?

_____

3. Parent's Information

Name _____ (Last / First / MI)

Employer _____

Birthdate ___/___/___ Relationship to Patient _____

Home Address _____

_____ (City / State / Zip)

Work# _____ Ext. _____

Home/Cell # _____

SS# _____ DL# _____

4. Parent's Information

Name _____ (Last / First / MI)

Employer _____

Birthdate ___/___/___ Relationship to Patient _____

Home Address _____

_____ (City / State / Zip)

Work# _____ Ext. _____

Home/Cell # _____

SS# _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? _____

Email address _____

NOTE: the parent or Guardian who accompanies the child is responsible for payment at the time of service.

6. SMS Text Messaging Consent

I **consent to receiving text messages to the cell number provided**

☐ **Y** ☐ **N**

*By checking this box, I consent to receive SMS from Steele Pediatric Dentistry. Reply STOP to opt-out; Reply HELP for support; Message & data rates may apply; Messaging frequency may vary. Visit https://www.eastindypediatricdentist.com/assets/uploads/docs/privacy-policy.pdf to see our privacy policy and https://www.eastindypediatricdentist.com/assets/uploads/docs/terms-of-use.pdf for our Terms of Service."

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ___/___/___

Policy Owner's Soc. Sec # OR Subscriber ID# _____

Employer _____

Insurance Plan Group # _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ___/___/___

Policy Owner's Soc. Sec # OR Subscriber ID# _____

Employer _____

Insurance Plan Group # _____

9. Dental History

Is this your child's first visit to the dentist: Yes No

If not, how long since the last visit to the dentist? _____

Previous Dentist's name _____

Were any x-rays taken at previous dental visits? _____

Have there bee any injuries to the teeth, face or mouth? Yes No

If yes, please explain _____

_____

Why did you bring your child to the dentist today?

_____

What is your child's usual snack? _____

What is your child's usual drink? _____

Does your child have a thumb/finger/pacifier habit? Yes No

Has your child ever had a serious or difficult problem associated with previous dental work? If yes, explain _____

_____

If your child's water fluoridated? Yes No

Is your child taking fluoride supplements? Yes No

Has your child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? Yes No

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

Floss his/her teeth daily? Yes No

10. Health History

Has your child ever had any of the following conditions?

Y N	Abnormal bleeding/bruising	Y N	Special Needs
Y N	Asthma/breathing problems	Y N	ADD/ADHD
Y N	Any Hospital stays	Y N	Autism
Y N	Any Operations	Y N	Psychological/Emotional problems
Y N	Allergies to any drugs	Y N	Hearing/Vision problems
Y N	Anemia/Sickle cell anemia	Y N	Speech difficulties
Y N	Blood transfusions	Y N	Rheumatic or scarlet fever
Y N	Cancer	Y N	Cerebral Palsy/Spina Bifida
Y N	Heart problems/Murmur	Y N	Muscle weakness
Y N	Seizures/Epilepsy	Y N	Joint replacement
Y N	Pregnancy	Y N	Stomach/digestive problems/reflux
Y N	Tuberculosis	Y N	Problems with growth
Y N	Hepatitis/jaundice	Y N	HIV/AIDS
Y N	Kidney/liver problems	Y N	Diabetes

Please discuss any serious medical conditions your child has had

_____

_____

_____

Please list all drugs your child is currently taking _____

_____

Please list all allergies _____

_____

Are your child's immunizations up to date? Yes No

Child's physician _____

Phone _____

The information I have given is correct to the best of my knowledge, and I understand that it is my responsibility to inform this office an any changes in my child's medical status. I also acknowledge that I have been given a copy of this office's Notice of Privacy Practices. (You may refuse to sign this acknowledgement.) I assume and agree to be responsible for "reasonable collection fees", "reasonable attorney fees", filing fees, and "administrative fees:, court costs and any other costs incurred while collecting the principal amount due and owing if the account enters a default status.

I authorize the dental staff to perform the necessary dental services my child may need.

I understand and agree that if someone other than a parent or guardian brings my child to their dental appointment, the staff of Steele Pediatric Dentistry may discuss my child's health and treatment information with that person. I give permission for treatment related decisions to be made by individual(s) accompanying my child to his/her dental appointment in my absence.

_____ _____ _____

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 _____

Date of last cleaning: _____

Notes: _____

_____