Welcome!

Steele Pediatric Dentistry
9602 East 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 _____/_____/_____ Child's Age _____

School_____Grade_____

Child's Home # (_____)_____

Child's Home Address:_____

_____
City State Zip

Who does this child live with? _____

2. Who may we thank for referring you to our office?

_____

3. Parent's Information

Name _____

Employer _____

Birthdate _____/_____/_____ Relationship to Patient _____

Home Address _____

_____
City State Zip

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

4. Parent's Information

Name _____

Employer _____

Birthdate _____/_____/_____ Relationship to Patient _____

Home Address _____

_____
City State Zip

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship_____

Do you have legal custody of this child? ☐ Yes ☐ No

Email address_____

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

6. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

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

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

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

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

8. Dental History

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

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 been any injuries to the teeth, face or mouth? _____

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? Y N

Has your child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is 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

9. 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 Allergy to latex products	Y N Speech difficulties
Y N Anemia/sickle cell anemia	Y N Thyroid or other gland problems
Y N Blood transfusions	Y N Rheumatic or scarlet fever
Y N Cancer	Y N Cerebal 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 (_____) _____

10.

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 of 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 fee", court costs and any other costs incurred while collecting the principal amount due and owing of 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:_____

_____

_____