Preventive Dental Services
Happy Healthy Smiles

549 Grubstake Ave, Suite A • Homer, AK 99603 • (907) 235 - 1286

Please answer all questions on **both** sides, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. *Thank You.*

PATIENT INFORMATION

CHILD'S NAME _____ Nickname _____

❑ Male ❑ Female Birthdate _____ Age _____

❑ **Stepmother** ❑ **Guardian** ❑ **Foster** ❑ **Other**

MOTHER'S NAME _____ Birthdate _____ Social Security No. _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Mother's Occupation _____ Employer _____ Work Phone _____

❑ **Stepfather** ❑ **Guardian** ❑ **Foster** ❑ **Other**

FATHER'S NAME _____ Birthdate _____ Social Security No. _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Father's Occupation _____ Employer _____ Work Phone _____

With whom does this child reside? _____

PRIMARY DENTAL INSURANCE

Insured _____

Relationship to Patient _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co. Phone # _____ ID # _____

Insured Birthdate _____

Employee's S.S. No. _____

SECONDARY DENTAL INSURANCE

Insured _____

Relationship to Patient _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co. Phone # _____ ID # _____

Insured Birthdate _____

Employee's S.S. No. _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Phone _____ Work Phone _____

Relationship to Patient _____ Closest Relative _____ Phone No. _____

Family Physician _____ Phone No. _____

Whom may we thank for referring you? ❑ Patient/family ❑ Location/sign ❑ Website ❑ Radio
❑ Employee ❑ Dr./Specialist ❑ Other: _____

DENTAL HISTORY

Is this your child's first dental visit Yes No
Previous Dentist's Name? _____
Date of last visit: _____
Does your child feel nervous about having dental treatment? Yes No
Has your child ever had a bad dental experience? Yes No
Has your child been seen by an orthodontist? Yes No

Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? Yes No
Has your child ever been premedicated for dental work? Yes No
Does your child receive fluorid in vitamins, tablets, or water? Yes No

Dr.'s Notes: _____

HEALTH HISTORY

Is your child having any pain or discomfort at this time? Yes No
Has your child been hospitalized during the past 2 years? Yes No
Has your child been under the care of a medical doctor during the past 2 years? Yes No
Is your child currently taking any medications? Yes No
If yes, please list: _____
Has your child ever had a head injury? Yes No
Dr's Notes: _____

Has your child taken any medicine / drugs during the past 2 years? Yes No
If yes, please list: _____

Please list any serious medical condition(s) that your child has or has had: _____
Name of Physician: _____
Physician Phone #: _____

PLEASE CHECK "YES OR NO" TO THE FOLLOWING CONDITIONS:

Y	N		Y	N		Y	N	
		Allergies: _____			Chemotherapy / Cancer			Heart Murmur / Rheumatic Fever
		Antibiotics: _____			Congenital Heart Defect			Heart Surgery
		Aspirin			Cortisone Medicine			Hemophilia
		Latex			Cough / Tuberculosis (TB)			Hepatitis: A B C **(circle one)**
		Asthma:			Diabetes			High / Low Blood Pressure
		Seasonal			Down Syndrome			Hives
		Excercise induced			Emphysema / Asthma			Kidney Failure/Dysfunction
		ADHD/ ADD			Epilepsy / Seizures			Liver Disease / Yellow Jaundice
		Autism			Fainting / Dizzy Spells			Nervousness
		Blood Transfusion / Anemia			Fever Blisters / Cold Sores			Pain in Jaw Joint
		Bruise Easily			Frequent Headaches			Psychiatric Treatment
					Hay Fever / Sinus Trouble			Thyroid Disease

Dr.'s Notes:

DOES YOUR CHILD HAVE ANY OTHER HEALTH ISSUES WE SHOULD BE AWARE OF? IF YES, PLEASE LIST:

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child s medical status. I authorize the Doctors at Preventive Dental Services, P.C. and/or dental team to perform the necessary dental services my child needs.

Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

Medical History Update
(For Office Use Only

Date _____ Comments _____ Date _____ Comments _____
Parent's Signature _____ Parent's Signature _____
Date _____ Comments _____ Date _____ Comments _____
Parent's Signature _____ Parent's Signature _____