



## PERSONAL HEALTH HISTORY OF

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Please fill in the personal health history on the following pages. This information is an important aid in making a thorough evaluation of your child's dental health. It also allows us to more adequately plan for your child's emotional and dental needs. This important document, therefore, becomes an integral part of our continuing evaluation of your child's growth and development in these formative years.

Our thanks for your cooperation.

Stephen C. Levin, D.D.S.

## OUR MISSION

We, as a Pediatric dental team, are dedicated to provide excellence in total oral health care in an empathetic, caring atmosphere as we ourselves wish to be treated. We recognize our patients as unique individuals and strive to educate them to take responsibility for their own dental health. Mutually, we can achieve the best care for our patients so they can enjoy their natural teeth for a lifetime.

## GENERAL

Date \_\_\_\_\_

Full name of child \_\_\_\_\_

"Nickname," if used \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Parent's First Name (Father) \_\_\_\_\_ (Mother) \_\_\_\_\_

Billing Address (if other) \_\_\_\_\_

Parent's Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Father Employed by: \_\_\_\_\_ Position \_\_\_\_\_

Address of Employer \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

Mother Employed by: \_\_\_\_\_ Position \_\_\_\_\_

Address of Employer \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

In case of emergency during office hours, who may we call? \_\_\_\_\_

Who referred you to our office? Name \_\_\_\_\_

Address \_\_\_\_\_

Name of child's physician \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of most recent medical examination \_\_\_\_\_

## MEDICAL

### Condition of Child's Health

1) Does your child have a history of any of the following problems? If Yes, describe on line below.

- Heart Problem  Rheumatic Fever  Brain Injury  Asthma  Seizures  
 Bleeding Disorder  Ear Infection or Other Ear Problems  Hepatitis  Aids  
 Hearing Disorder/Difficulty  Sight Disorder/Difficulty  Speech Disorder/Difficulty  
 Coordination Problems  Special Schooling  Hyperactivity

2) Is your child physically or mentally handicapped?  Yes  No

3) If your child is mentally handicapped, does he/she follow simple directions?  Yes  No

4) Has your child had any bumps or blows to the head & neck area?  Yes  No

5) Did it result in hospitalization?  Yes  No

When? \_\_\_\_\_

Where? \_\_\_\_\_

6) Please indicate any health problem not listed above. \_\_\_\_\_

7) Is your child receiving any medication now?  Yes  No

What? \_\_\_\_\_

Dosage? \_\_\_\_\_

8) Does your child have any allergies to foods, medications or other things?  Yes  No

If so, please list \_\_\_\_\_

9) Was the term of pregnancy and birth normal with respect to your child?  Yes  No

If No, please state any complications or problems including prematurity and low birth weight. \_\_\_\_\_

10) Has your child ever had any kind of dental or medical surgery?  Yes  No

If yes, for what, when, and by whom? \_\_\_\_\_

## DENTAL

- 1) Is this your child's first visit to a dentist?  Yes  No  
If not, how long since his last visit to a dentist? \_\_\_\_\_
- 2) Has your child experienced any unfavorable or undesirable reaction from any previous dental or medical care?  Yes  No
- 3) Has any member of the family ever had an unusual dental history such as missing or extra teeth?  Yes  No
- 4) Does your child have a history of:  
 Thumb-Sucking  Tongue Thrusting  Nail Biting  
 Bed-Wetting  Mouth Breathing  Pacifier  
Other \_\_\_\_\_
- 5) Has there been any injury to any of your child's teeth by fall, bump, blow or otherwise?  Yes  No  
If so, describe: \_\_\_\_\_
- 6) Was your child bottle-fed?  Yes  No  
For how long? \_\_\_\_\_  
Was your child ever put to bed with a bottle?  Yes  No
- 7) At what age did teeth first appear? \_\_\_\_\_  
Where?  Upper  Lower  Front  Back
- 8) Are you concerned about any dental problems now?  Yes  No  
If yes, please describe \_\_\_\_\_
- 9) Is your child experiencing any dental pain or discomfort now?  Yes  No  
If yes, explain \_\_\_\_\_
- 10) Did parents or any other children in the family have braces or other orthodontic treatment?  Yes  No  
If yes, When? \_\_\_\_\_  
By Whom? \_\_\_\_\_  
Were you satisfied? \_\_\_\_\_  
Were any teeth extracted while in treatment? \_\_\_\_\_
- 11) Are you happy with the way your child's teeth look?  Yes  No  
If no, why? \_\_\_\_\_
- 12) Does your child have headaches?  Yes  No  
Neck Aches?  Yes  No  
Jaw Pain?  Yes  No
- 13) Does your child's jaw make a Popping Noise? Clicking Noise? Grinding Noise?  Yes  No
- 14) Does he/she clench or grind his/her teeth?  Yes  No
- 15) What do you think of the condition of your child's mouth? \_\_\_\_\_
- 16) Do you have well water?  Yes  No  
If yes, is your child on a fluoride supplement?  Yes  No
- 17) Please list any questions you would like to have answered.  
\_\_\_\_\_  
\_\_\_\_\_
- 18) What are your child's hobbies? \_\_\_\_\_  
Favorite Sport? \_\_\_\_\_
- 19) Names and birthdates of other children:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## FINANCIAL

### Insurance Coverage of Dental Services

A) Dental Insurance

Yes  No

If yes, complete the following:

**Primary Insurance Company:** \_\_\_\_\_

Group Insurance \_\_\_\_\_

Group Policy Number \_\_\_\_\_

Social Security # \_\_\_\_\_

Address of Carrier \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

Group Insurance \_\_\_\_\_

Group Policy Number \_\_\_\_\_

Social Security # \_\_\_\_\_

Address of Carrier \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_

### Signature on File:

I have determined the following treatments plan. I authorize my dentist to obtain information or to determine benefits for the duration of this claim.

\_\_\_\_\_  
Insured Signature

I hereby authorize payment directly to the named dentist for the service described.

\_\_\_\_\_  
Insured Signature

## BILLING INFORMATION

We will be pleased to assist you to the best of our ability in effecting payment on services covered by your insurance policy. Please bring your insurance forms with you at the first visit. Please understand that assisting you with your insurance needs is done willingly but regardless of insurance coverage, THE OBLIGATION OF THE BILL FOR SERVICES RENDERED IS THE PARENTS. Both parents are jointly and severally responsible for payment of our services. We currently accept all major credit cards. If you feel it is necessary for a treatment plan to be arranged, please do so beforehand with our financial coordinator. There will be a finance charge of eighteen percent (18%) per annum applied to all accounts over 90 days. There will also be a charge for all returned checks in the amount of \$25.00. In the event that this account is turned over to an attorney for collection, whether or not suit is filed, the undersigned agree to pay attorney fees equal to thirty percent (30%) of the unpaid balance.

We believe that understanding and cooperation are the utmost importance. Please feel free to ask any questions you may have about your child's treatment or fees.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_