

CHILD HEALTH RECORD

Today's Date: _____

Full Name _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Names of Both Parents _____ Hm. Phone _____

Father's Employer _____ Soc. Sec. _____ Work Phone _____ Cell Phone _____

Mother's Employer _____ Soc. Sec. _____ Work Phone _____ Cell Phone _____

Dental Insurance Co. _____ Group No. _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Reason for this visit _____

**Name and address
 of a relative
 not living with you.**

DENTAL HISTORY		MEDICAL HISTORY	
How long since your child's last dental visit?		<i>Has your child ever had any of the following?</i>	
		Heart problems	YES NO
Is he/she having problems now? If yes, explain.		Diabetes	YES NO
		Fainting spells, seizures, or epilepsy	YES NO
Has your child had any unhappy dental experiences?		Ulcers or stomach problems	YES NO
		Nervous problems	YES NO
Has your child had any injuries to his/her mouth, teeth or head? If yes, explain.		Asthma or any respiratory problems	YES NO
		Hepatitis, or any liver damage	YES NO
Has your child had nitrous oxide before (laughing gas)?		Abnormal Bleeding	YES NO
		Surgery or Radiation for any growths, cancer or tumors	YES NO
Would you like them to have laughing gas for dental treatment?		Is he/she taking ANY MEDICATIONS now	YES NO
		Name them:	
Does your child have any mouth habits? Thumb sucking, nail biting, mouth-breathing, nursing bottle habits, etc.?		Is he/she ALLERGIC TO PENICILLIN	YES NO
		ANY OTHER DRUG ALLERGIES	YES NO
Does your child have any unusual speech habits?		If so, to what	
Has orthodontic treatment been recommended?		Is your child under a PHYSICIAN'S CARE right now	
		If so, explain	
Does your child brush their teeth daily?		FAMILY PHYSICIAN: _____ PHONE#: _____	
Do you assist your child with brushing their teeth?		Is there any other MEDICAL OR DENTAL information that you feel I should know about?	
Is dental floss used?			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Insurance Agreement: I certify that I and/or my dependents have insurance coverage with _____
 Name of Insurance Company

and assign directly to Dr. Brice 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. Any benefit coverage quoted is an estimate based on the most current information available to us. Billing and/or interest charges are applied to balances over 30 days (rate of 1.56% or min. \$1.00 authorize the use of my signatures on all insurance submissions).

Dr. Brice may use health care information and may disclose such information to the above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Brice's Notice of Privacy Practices.

X: _____

Date: _____

Signature of Patient, Parent or Guardian