BRICE DENTAL
Making Friends Smile
GENERAL & IMPLANT DENTISTRY

CHILD HEALTH RECORD

Today's Date:_____

Full Name_____ Age_____ Date of Birth_____

Home Adress_____ 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

How long since your child's last dental visit?		
Is he/she having problems now? If yes, explain.	YES	NO
Has your child had any unhappy dental experiences?	YES	NO
Has your child had any injuries to his/her mouth, teeth or head? If yes, explain.	YES	NO
Has your child had nitrous oxide before (laughing gas)?	YES	NO
Would you like them to have laughing gas for dental treatment?	YES	NO
Does your child have any mouth habits? Thumb sucking, nail biting, mouth-breathing, nursing bottle habits, etc.?	YES	NO
Does your child have any unusual speech habits?	YES	NO
Has orthodontic treatment been recommended?	YES	NO
Does your child brush their teeth daily?	YES	NO
Do you assist your child with brushing their teeth?	YES	NO
Is dental floss used?	YES	NO

MEDICAL HISTORY

Has your child ever had any of the following?

Heart problems	YES	NO
Diabetes	YES	NO
Fainting spells, seizures, or epilepsy	YES	NO
Ulcers or stomach problems	YES	NO
Nervous problems	YES	NO
Asthma or any respiratory problems	YES	NO
Hepatitis, or any liver damage	YES	NO
Abnormal Bleeding	YES	NO
Surgery or Radiation for any growths, cancer or tumors	YES	NO
Is he/she taking ANY MEDICATIONS now Name them:	YES	NO
Is he/she ALLERGIC TO PENICILLIN	YES	NO
ANY OTHER DRUG ALLERGIES If so, to what	YES	NO
Is your child under a PHYSICIAN'S CARE right now If so, explain		
FAMILY PHYSICIAN:_____ PHONE#:_____		
Is there any other MEDICAL OR DENTAL information that you feel I should know about?		

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