SHREWSBURY PEDIATRIC DENTISTRY
PATIENT HEALTH HISTORY

We would like to WELCOME you and your child to our office. We are a practice based on preventative care. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime. Please PRINT all information CLEARLY.

Patient's Full Name: _____Age: _____Date of Birth: ____/_____/____
First Middle Last
Address: _____ City: _____ State: _____Zip: _____

Home Phone Number: (____) _____-_____ Sex :(M) (F) Weight: _____lbs. E-Mail: _____

Mother's Cell Phone # _____ Father's Cell Phone # _____ Other # _____

Name of Physician: _____ Phone: (___) _____-_____Name & Phone # of Pharmacy: _____

Whom may we thank for your referral? **(please specify)**

1. Sibling _____ 4. Dr._____ 6. Insurance _____
2. Internet _____ 5. Newspaper/Magazine_____ 7. Yellow pages _____
3. Friend/Word of mouth (Name) _____ 8. Other _____

DENTAL AND MEDICAL HISTORY

1. What is the chief concern regarding the patients oral health? _____
2. Has the patient had any injuries to the face, mouth, or teeth? _____Yes No
3. Has the patient had any unusual or unpleasant experiences in a dental or medical office? _____ Yes No
4. Were there any problems during pregnancy, delivery or during the child's first year of life? _____Yes No
5. Is the child currently under the care of a physician? _____Yes No
6. Has the child been in the hospital or had surgery/operation? _____ Yes No
7. Is the child currently taking any medicine? (Prescription, Vitamins, OTC, Herbal) If yes, please list. _____
_____
8. Is your child allergic to any types of medicines? If yes, please list medicine and reaction. _____
_____
9. Is your child currently taking fluoride supplements? If yes, please list _____
10. Please discuss any serious medical problems that the child has had: _____
_____
11. Has your child had a history of: (Please circle Yes or No)

*** If yes to any of the asterisk condition, please call prior to your appointment….premedication may be required**.

Congenital Heart Defects*	Yes No	Allergies (please list)	Yes	No	_____
Mitral Valve Prolapse*	Yes No	Latex Allergy	Yes	No	
Heart Murmur*	Yes No	Diabetes (please list type)	Yes	No	_____
Heart Murmur (innocent)	Yes No	Stomach/Intestinal Disorder	Yes	No	
Rheumatic Fever*	Yes No	Tuberculosis/Lung Disease	Yes	No	
High/Low Blood Pressure	Yes No	Attention Deficit Disorder	Yes	No	
Bleeding Disorder	Yes No	Epilepsy	Yes	No	
Sickle Cell Anemia*	Yes No	Seizures	Yes	No	
Liver Disease	Yes No	Developmentally Delayed	Yes	No	
Kidney Disease	Yes No	Cancer*	Yes	No	
Chronic Ear Infections	Yes No	Hepatitis	Yes	No	
Tonsillitis	Yes No	Autism Spectrum	Yes	No	
Snoring	Yes No	Speech Problems	Yes	No	
Asthma	Yes No	Hearing Impairment	Yes	No	

Other (please list): _____

12. Does your child have any of the following habits? Finger Sucking Pacifier Clenching/Grinding Nail Biting Other
13. Is there a history of Missing or an Abnormal Number of Teeth in the Family? If yes, list_____
14. Child's Interests, hobbies or pets _____

Please circle any of the following that may describe your child:

Outgoing	Shy	Stubborn	Anxious	Nervous
Defiant	Curious	Moody	Friendly	Cooperative

I understand the information that I have given is correct to the best of my knowledge and will be held in strict confidence.
I hereby give consent to the dentist and staff to perform the dental treatment necessary to correct any oral problems the above child may have. I have been given an opportunity to ask any questions I might have and all questions have been answered in a satisfactory manner.

Parent/Guardian
Signature_____ Date_____

Dentist
Signature_____ Date_____

Shrewsbury Pediatric Dentistry

Guarantor Form/Insurance Information

Patient(s) name & Date of Birth: _____

_____

_____

Responsible Parties' Information:

Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Relationship to Patient: _____	Relationship to Patient: _____
D.O.B. : _____	D.O.B.: _____
Home #: _____	Home #: _____
Cell #: _____	Cell #: _____
Email: _____	Email: _____

Primary **DENTAL Insurance:**

Name of Policy Holder: _____

Insurance Company Name: _____

Policy Holder's Employer: _____

Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth: _____

Insurance Group Number: _____ ID#: _____

Insurance Company Phone Number: _____

Secondary **Dental Insurance:**

Name of Policy Holder: _____

Insurance Company Name: _____

Policy Holder's Employer: _____

Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth: _____

Insurance Group Number: _____ ID#: _____

Insurance Company Phone Number: _____

In order to control the cost of dental services we require payment be made at the time of service, unless otherwise discussed with our Office Manager. Payment can be made in the form of cash, personal check, money order, Visa, MasterCard, Discover, American Express or CareCredit. If for any reason your check payment is returned to us, the office reserves the right to charge a $25 fee. _____ **(initial)**

We must be notified of any cancellation at least 24 hours prior to the appointment. The office reserves the right to charge a $50 fee for a broken appointment. _____ **(initial)**

I authorize release of any information relating to any claims and the right to charge a fee of $25 if my account goes to an outside collection agency. I understand that I am responsible for all cost of dental treatment.

_____ _____

(Signature of Responsible Party) **(Date)**