

Welcome Kids!
PATIENT INFORMATION AND HEALTH HISTORY

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Today's Date: _____

PATIENT INFORMATION

ABOUT YOUR CHILD

Child's Full Name: _____
 Nickname: _____ Male Female
 Child's Birthdate: _____ Age: _____
 Email Address: _____
 School: _____ Grade: _____
 Child's Home Phone: _____
 Child's SS#: _____
 Child's Home Address: _____
 City: _____ State: _____ Zip: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____
 Relation: _____
 Do you have legal custody of this child? No Yes
 Is the child adopted No Yes
 Is the child in a foster home? No Yes
 Whom may we thank for referring you? _____
 Other siblings seen by us: _____
 Previous / Present Dentist: _____
 Last Visit Date: _____
 Parent's Marital Status:
 Single Married Divorced Widowed Separated

PARENT'S INFORMATION:

MOTHER Mother Stepmother Guardian
 Name: _____ Birthdate: _____
 Work Phone: _____ Home Phone: _____
 Employer: _____
 Length of Employment: _____ SS#: _____
FATHER Father Stepfather Guardian
 Name: _____ Birthdate: _____
 Work Phone: _____ Home Phone: _____
 Employer: _____
 Length of Employment: _____ SS#: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____
 Billing Address: _____
 City: _____ State: _____ Zip: _____
 Relationship: _____
 Driver's License#: _____ SS #: _____
 Employer: _____
 Work Phone: _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE COMPANY:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Group # (Plan, Local, or Policy#): _____
 Orthodontic Coverage? No Yes
INSURED PERSON'S INFORMATION:
 Name: _____
 Birthdate: _____
 SS #: _____
 Employer: _____
 Employer Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Relationship to Patient: _____

SECONDARY DENTAL INSURANCE COMPANY:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Group # (Plan, Local, or Policy#): _____
 Orthodontic Coverage? No Yes
INSURED PERSON'S INFORMATION:
 Name: _____
 Birthdate: _____
 SS #: _____
 Employer: _____
 Employer Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Relationship to Patient: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name: _____
 Relationship to Patient: _____
 Work Phone: _____
 Home Phone: _____

MEDICAL HISTORY

Has the child experienced any of the following diseases / medical problems?

- | | | | |
|------------------------------|--|---------------------|--|
| Abdominal Bleeding | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Murmur | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| ADD / ADHD | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hemophilia | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| AIDS | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Any Hospital Stays | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hives | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Any Operations | <input type="checkbox"/> No <input type="checkbox"/> Yes | HIV+ | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes | Learning Disability | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chicken Pox | <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Congenital Heart Defect | <input type="checkbox"/> No <input type="checkbox"/> Yes | Low Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Convulsions | <input type="checkbox"/> No <input type="checkbox"/> Yes | Measles | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Mononucleosis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Exposed to HIV, but not Neg. | <input type="checkbox"/> No <input type="checkbox"/> Yes | Scarlet Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Handicaps / Disabilities | <input type="checkbox"/> No <input type="checkbox"/> Yes | Skin Rash | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hearing Impairment | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tuberculosis (TB) | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Other: _____

Anything you would like to discuss with the Doctor in Private? No Yes

Are the child's immunizations current? No Yes

Please list any serious medical problems the child experiences / ed:

Does / did the child have any of the following habits:

- | | | | |
|----------------------------|--|------------------------|--|
| Breast Fed | <input type="checkbox"/> No <input type="checkbox"/> Yes | Nursing Bottle Habits | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chewing on Objects | <input type="checkbox"/> No <input type="checkbox"/> Yes | Speech Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Clenching / Grinding Teeth | <input type="checkbox"/> No <input type="checkbox"/> Yes | Thumb / Finger Sucking | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Lip Sucking / Biting | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tounge / Cheek Biting | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Mouth Breather | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tongue Thrust | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Nail Biting | <input type="checkbox"/> No <input type="checkbox"/> Yes | Used Pacifier | <input type="checkbox"/> No <input type="checkbox"/> Yes |

DENTAL HISTORY

What is the primary reason for today's visit? _____

Is the child's water flouridated? No Yes

Has the child experienced problems with any previous dental work? No Yes

Is the child taking flouridated supplements? No Yes

Has the child ever experienced an injury to the mouth, teeth or jaw? No Yes

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? No Yes

Does the child brush his / her teeth daily? No Yes

Floss his / her teeth daily? No Yes

Child's Physician: _____

Phone: _____

Date of last visit?: _____

Is the child currently under the care of a physician? No Yes

Please describe the child's current physical health:
 Good Fair Poor

Has the child ever taken Phen-Fen? No Yes

If so, when?: _____

Please list all drugs the child is currently taking:

Please list all drugs / things that cause the child allergic reactions: _____

PATIENT AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. It 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 dental staff to perform the necessary dental services my child may need.

Signature _____ Date: _____

The parent or guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been approved.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent /guardian & patient named herein.

Initials: _____ Date: _____ Doctor's Comments: _____

MEDICAL HISTORY UPDATES

DATE	SIGNATURE	COMMENTS