

# Child Health History Form

Today's date: \_\_\_\_\_



## ABOUT YOUR CHILD

Child's name: \_\_\_\_\_  Female  Male

Nickname: \_\_\_\_\_

Address: \_\_\_\_\_

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

Home phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

What is your child's favorite sport? \_\_\_\_\_

Favorite toy? \_\_\_\_\_ Favorite hobby? \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

Father's name: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Mother's name: \_\_\_\_\_

Cell phone: \_\_\_\_\_



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## DENTAL INSURANCE INFORMATION

Name of policy holder: \_\_\_\_\_

Policy holder's ID/social security #: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy holder's birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy holder's employer: \_\_\_\_\_

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Stephen P. Boger Dental, DDS, PA. Guardian's Initials: \_\_\_\_\_

## APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once will result in a \$50 charge and then discontinuation of services.

Guardian's Initials: \_\_\_\_\_

## DENTAL HISTORY

Is this your child's first dental experience?  Yes  No

What is his/her attitude toward this visit? \_\_\_\_\_

How has he/she responded to past visits to the physician and/or dentist?

Very well  Moderately well  Moderately poor  Very poorly

How would you rate your own anxiety (fear, nervousness) at this moment?

High  Moderately high  Moderately low  Low

Does your child think there is anything wrong with his or her teeth, such as a chipped tooth, decayed tooth, gumboil, etc.?

Yes  No If yes, please explain: \_\_\_\_\_

How do you expect your child to behave in the dental chair?  Very well  Moderately well  Moderately poor  Very poorly

How much and how often does your child drink juices or soda pop? \_\_\_\_\_

Does/did your child suck their thumb?  Yes  No If so, how often? \_\_\_\_\_

Does/did your child use a pacifier?  Yes  No If so, how often? \_\_\_\_\_

## MEDICAL HISTORY

Is your child in good health?  Yes  No

Child's physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

When was your child's last medical exam? \_\_\_\_\_

Has your child required hospitalization or had a serious illness?  Yes  No

If yes, please explain: \_\_\_\_\_

Are your child's immunizations up-to-date?  Yes  No

Is your child sensitive/allergic to anything?  Yes  No

If yes, please explain: \_\_\_\_\_

Is your child presently taking any medications?  Yes  No

If yes, please explain: \_\_\_\_\_

Please check any of the following that apply to you:

- |   |                                      |  |  |
|---|--------------------------------------|--|--|
| <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Counseling            |
| <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Hay fever   | <input type="checkbox"/> Breathing disorders | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Anemia      | <input type="checkbox"/> Hearing impairment  | <input type="checkbox"/> Visual impairment     |
| <input type="checkbox"/> Attention disorder | <input type="checkbox"/> Other _____ |  |  |

Is there any additional information that you feel would be helpful in meeting your personal needs?: \_\_\_\_\_

Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_



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