Simply Kids Dentistry of Orlando

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Board Certified by the American Board of Pediatric Dentistry
407-295-KIDS (5437)

Health History Form

Today's Date: ______________________

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service

1 Tell us about your Child

Child's Name ______________________________
Last First MI

Goes by ____________________ ☐ Male ☐ Female

Siblings that we treat ____________________

Child's Birthdate _____/_____/_____ Child's Age ________

School ____________________ Grade _______

Child's Home # (________) ____________________

SS# ____________________

Child's Home Address ____________________

____
City State Zip

Child's Favorite Hobby: ____________________

Sport: ____________________ Pets: ____________________

2 Who may we thank for referring you to our office?

____

3 Mother's Information

Name ____________________
Mother Stepmother Guardian Birthdate _____/_____/___

Employer ____________________

Work # (________) ____________________

Home # (________) ____________________

Cellular Phone # (________) ____________________

SS # ____________________ DL# ____________________

Email Address ____________________

4 Fathers Information

Name ____________________

Father Stepfather Guardian Birthdate _____/_____/___

Employer ____________________

Work # (________) ____________________

Home # (________) ____________________

Cellular Phone # (________) ____________________

SS # ____________________ DL# ____________________

Email Address ____________________

5 Who is accompanying the child today?

Name ____________________

Relationship ____________________

Do you have legal custody of this child? ☐ Yes ☐ No

6 Person responsible for account?

Name ____________________

Relationship ____________________

Billing Address ____________________

____
City State Zip

Home # (________) ____________________

Work # (________) ____________________

Cellular Phone # (________) ____________________

Email Address ____________________

7 Primary Dental Insurance

Insurance Co. Name ____________________

Insurance Co. Address ____________________

____

Insurance Co. Phone # (________) ____________________

Group # (Plan, Local, or Policy #) ____________________

Policy Holder's Name ____________________

Relationship to Patient ____________________

Birthdate _____/_____/___

Social Security # ____________________

Employer ____________________

8 Secondary Dental Insurance

Insurance Co. Name ____________________

Insurance Co. Address ____________________

____

Insurance Co. Phone # (________) ____________________

Group # (Plan, Local, or Policy #) ____________________

Policy Holder's Name ____________________

Relationship to Patient ____________________

Birthdate _____/_____/___

Social Security # ____________________

Employer ____________________

9 Dental History

Is this your child's first visit to the dentist?__________

If not, how long since the last visit to the dentist? __________

Previous Dentist's Name __________

Were any x-rays taken at previous dental visits? __________

Have there been any injuries to the teeth, face or mouth? __________

If yes, please explain __________

Why did you bring the child to the dentist today? __________

Is your child currently being seen by an orthodontist? Yes No

Orthodontist's Name __________

Does the child have any of the following habits?

Y N Lip Sucking / Biting

Y N Nail Biting

Y N Nursing / Bottle Habits

Y N Thumb / Finger Sucking

Y N Grinding

Has the child ever had a difficult problem or behavioral issues associated with previous dental work? Yes No

If yes, please explain __________

Is the child's water fluoridated?	Yes	No
Is the child taking fluoride supplements?	Yes	No
Is the child using toothpaste with fluoride?	Yes	No
Do we have your permission to treat your child's teeth with fluoride?	Yes	No
Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)	Yes	No
Does the child brush his/her teeth daily?	Yes	No
Number of times __________		
Floss his/her teeth daily?	Yes	No

10 Healthy History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N Allergies to any Drugs

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Birth Defects

Y N Convulsions/Epilepsy

Y N Pregnancy

Y N Tuberculosis

Y N ADD/ADHD

Y N Special Needs/Disabilities

Y N Hearing Impairment

Y N Heart Disease/Murmur

Y N Hemophilia/Blood Disorders

Y N Hepatitis

Y N HIV + / AIDS

Y N Kidney/Liver Conditions

Y N Rheumatic/Scarlet Fever

Y N Allergies to Latex Product

Y N Diabetes

Y N Glandular/Hormonal Disorder

Please discuss any serious medical conditions the child has had __________

Please list all drugs the child is currently taking __________

Please list all drugs the child is allergic to __________

Child's Physician __________

Phone (______) __________

Date of last physical exam __________

Results (please circle one) : good fair poor

Child's weight __________ Child's height __________

Immunization up to date: Yes No

Does your child need to be pre-medicated before dental appointment: Yes No

CONSENT FOR DENTAL TREATMENT

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I do hereby request and authorize Dr. David Goldstein and his staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, fluoride treatment, any necessary dental treatment for my child's teeth, X-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Dr. Goldstein; whether or not I am present when the treatment is rendered. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Goldstein will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments. I will be responsible for any charges incurred for my child for dental treatment.

Signature:__________ **Date:** __________