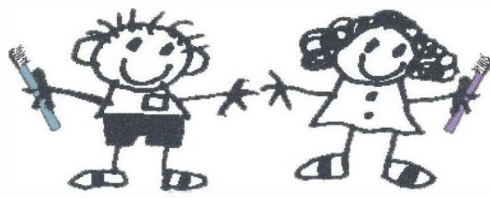


# Welcome!



Steele Pediatric Dentistry  
9602 East Washington Street Indianapolis, IN 46229  
Phone: 317-899-KIDS FAX: 317-897-0771

## Health History Form

Today's Date: \_\_\_\_\_

### 1. Tell Us About Your Child

Child's Name \_\_\_\_\_  
Goes by: \_\_\_\_\_  
Last First MI Male  Female   
Siblings that we treat \_\_\_\_\_  
Child's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home# (\_\_\_\_\_) \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_  
City State Zip  
Who does this child live with? \_\_\_\_\_

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

### 3. Parent's Information

Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to patient \_\_\_\_\_  
Home Address \_\_\_\_\_  
City State Zip  
Work#(\_\_\_\_\_) Ext. \_\_\_\_\_  
Home#(\_\_\_\_\_) \_\_\_\_\_  
Cellular Phone#(\_\_\_\_\_) \_\_\_\_\_  
SS# \_\_\_\_\_ DL# \_\_\_\_\_

### 4. Parent's Information

Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to patient \_\_\_\_\_  
Home Address \_\_\_\_\_  
City State Zip  
Work#(\_\_\_\_\_) Ext. \_\_\_\_\_  
Home#(\_\_\_\_\_) \_\_\_\_\_  
Cellular Phone#(\_\_\_\_\_) \_\_\_\_\_  
SS# \_\_\_\_\_ DL# \_\_\_\_\_

### 5. Who is Accompanying the Child Today?

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Do you have legal custody of this child?  Yes  No  
Email address \_\_\_\_\_

**Note: The parent or Guardian who accompanies the child is responsible for payment at the time of service.**

### 6. Primary Dental Insurance

Insurance Co. Name \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insurance Co. Phone# \_\_\_\_\_  
Group # (Plan, Local, or Policy#) \_\_\_\_\_  
Policy Owner's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security# \_\_\_\_\_  
Policy Owner's Employer \_\_\_\_\_

### 7. Secondary Dental Insurance

Insurance Co. Name \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insurance Co. Phone# \_\_\_\_\_  
Group # (Plan, Local, or Policy#) \_\_\_\_\_  
Policy Owner's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security# \_\_\_\_\_  
Policy Owner's Employer \_\_\_\_\_