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 _____ (Last First MI)
Goes by: _____ ☐ 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 a 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 _____