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 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 ______________________________

8. 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 your child to the dentist today? __________

____

____

What is your child's usual snack? ____________________

What is your child's usual drink? ______________________

Does your child have a thumb/finger/pacifier habit? Y N

Has your child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain ________________________________

____

Is your child's water fluoridated? Yes No

Is your child taking fluoride supplements? Yes No

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

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

Floss his / her teeth daily? Yes No

9. Health History

Has your child ever had any of the following conditions?

- Y N Abnormal bleeding/bruising
- Y N Asthma/breathing problems
- Y N Any Hospital Stays
- Y N Any Operations
- Y N Allergies to any drugs
- Y N Allergy to latex products
- Y N Anemia/sickle cell anemia
- Y N Blood transfusions
- Y N Cancer
- Y N Heart problems/murmur
- Y N Seizures/epilepsy
- Y N Pregnancy
- Y N Tuberculosis
- Y N Hepatitis/jaundice
- Y N Kidney/liver problems
- Y N Special Needs
- Y N ADD/ADHD
- Y N Autism
- Y N Psychological/emotional problems
- Y N Hearing/vision problems
- Y N Speech difficulties
- Y N Thyroid or other gland problems
- Y N Rheumatic or scarlet fever
- Y N Cerebal Palsy/Spina Bifida
- Y N Muscle weakness
- Y N Joint replacement
- Y N Stomach/digestive problems/reflux
- Y N Problems with growth
- Y N HIV/AIDS
- Y N Diabetes

Please discuss any serious medical conditions your child has had

____

____

____

Please list all drugs your child is currently taking_______________

____

____

Please list all allergies________________________________

____

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

Child's Physician ___________________________________

Phone (_____________)_______________________________

10.

The information I have given is correct to the best of my knowledge, and I understand that it is my responsibility to inform this office of any changes in my child's medical status. I also acknowledge that I have been given a copy of this office's Notice of Privacy Practices. (You may refuse to sign this acknowledgement.) I assume and agree to be responsible for "reasonable collection fees", "reasonable attorney fees", filing fees, and "administrative fee", court costs and any other costs incurred while collecting the principal amount due and owing of the account enters a default status.

I authorize the dental staff to perform the necessary dental services my child may need.

I understand and agree that if someone other than a parent or guardian brings my child to their dental appointment, the staff of Steele Pediatric Dentistry may discuss my child's health and treatment information with that person. I give permission for treatment related decisions to be made by individual(s) accompanying my child to his/her dental appointment in my absence.

____ ______________________________

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

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

Initials _____________ Date _______________

Date of last cleaning: ____________________________

Notes:____

____

____