Welcome!

Steele Pediatric Dentistry
9602 E. 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: _____ Gender: _____

Siblings that we treat: _____

Child's Birthdate: ___/___/___ Age: _____

School: _____ Grade: _____

Child's Home # _____

Child's Home Address: _____

_____ (City / State / Zip)

Who does this child live with? _____

2. How Did You Hear About Our Office?

_____

3. Parent's Information

Name _____ (Last / First / MI)

Employer _____

Birthdate ___/___/___ Relationship to Patient _____

Home Address _____

_____ (City / State / Zip)

Work# _____ Ext. _____

Home/Cell # _____

SS# _____ DL# _____

4. Parent's Information

Name _____ (Last / First / MI)

Employer _____

Birthdate ___/___/___ Relationship to Patient _____

Home Address _____

_____ (City / State / Zip)

Work# _____ Ext. _____

Home/Cell # _____

SS# _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? _____

Email address _____

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

6. SMS Text Messaging Consent

I consent to receiving text messages to the cell number provided

☐ **Y *also see other side** ☐ **N**

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ___/___/___

Policy Owner's Soc. Sec # OR Subscriber ID# _____

Employer _____

Insurance Plan Group # _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ___/___/___

Policy Owner's Soc. Sec # OR Subscriber ID# _____

Employer _____

Insurance Plan Group # _____

9. Dental History

Is this your child's first visit to the dentist: Yes No

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 bee any injuries to the teeth, face or mouth? Yes No

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? Yes No

Has your child ever had a serious or difficult problem associated with previous dental work? If yes, explain _____

_____

If your child's water fluoridated? Yes No

Is your child taking fluoride supplements? Yes No

Has your child ever had any paid 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

*By checking this box, I consent to receive SMS from Steele Pediatric Dentistry. Reply STOP to opt-out; Reply HELP for support; Message & data rates may apply; Messaging frequency may vary. Visit http://bit.ly/3XZpGAA to see our privacy policy and https://bit.ly/4iy1AF1 for our Terms of Service."

10. Health History

Has your child ever had any of the following conditions?

Y N Abnormal bleeding/bruising	Y N Special Needs
Y N Asthma/breathing problems	Y N ADD/ADHD
Y N Any Hospital stays	Y N Autism
Y N Any Operations	Y N Psychological/Emotional problems
Y N Allergies to any drugs	Y N Hearing/Vision problems
Y N Anemia/Sickle cell anemia	Y N Speech difficulties
Y N Blood transfusions	Y N Rheumatic or scarlet fever
Y N Cancer	Y N Cerebral Palsy/Spina Bifida
Y N Heart problems/Murmur	Y N Muscle weakness
Y N Seizures/Epilepsy	Y N Joint replacement
Y N Pregnancy	Y N Stomach/digestive problems/reflux
Y N Tuberculosis	Y N Problems with growth
Y N Hepatitis/jaundice	Y N HIV/AIDS
Y N Kidney/liver problems	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 _____

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 an 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 fees:, court costs and any other costs incurred while collecting the principal amount due and owing if 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: _____

_____