Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? ______________________

How often does your child floss? ______________________

Is your child's water fluoridated? ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of Last Dental Visit ______________________

Previous Dentist ______________________

Address ______________________

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No

Child's Physician ______________________ Phone # ______________________

Address ______________________

Previous Hospitalizations/Surgeries/Serious Illnesses ______________________ When? ______________________

______________________ ______________________

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list) ______________________

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) ______________________

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ______________________

Please explain any medical problems that your child has: ______________________

____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ Care Credit ☐ Discover

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the office of Harry M. Suekert, DDS, PLLC of any changes in my child's medical status. I also authorize the dental staff to perform routine diagnostic and preventive dental services including, but not limited to examination, simple cleaning, x-rays, fluoride treatment and oral hygiene instruction. I also authorize Harry M. Suekert, DDS, PLLC to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Harry M. Suekert, DDS, PLLC any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

____

Signature of Parent or Guardian Date

Dentist's Review: ______________________

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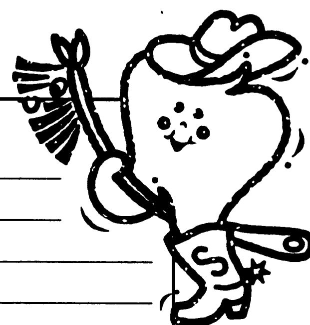
Signature Date

Welcome!
Thank you for selecting us!

Harry M. Suekert, DDS, PLLC
Family and Cosmetic Dentistry

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.



Your Child

Child's Name ____________________ Sex ________ Age ________

Nickname ____________ Social Security # ____________ Birthdate ____________

School ____________________ Grade ____________

Child's Home Address ____________________

City, State, Zip ____________________ Phone ____________

Parent or Guardian Information ☐ Mother ☐ Stepmother ☐ Guardian

Name ____________________

Home Phone ____________ Work Phone ____________

Employer ____________ Occupation ____________

Social Security # ____________ DL # ____________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ Father ☐ Stepfather ☐ Guardian

Name ____________________

Home Phone ____________ Work Phone ____________

Employer ____________ Occupation ____________

Social Security # ____________ DL # ____________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Who is Responsible for Making Appointments? ____________________

Responsible Party (If different from above.)

Name ____________________ Relationship ____________

Address ____________________

City, State, Zip ____________________ Phone ____________

Social Security # ____________ DL # ____________

Primary Insurance

Insured's Name ____________________ Relationship ____________

Birthdate ____________ Social Security # ____________

Employer ____________________ Occupation ____________

Insurance Co. ____________ Group # ____________ Employee # ____________

Ins. Co. Address ____________ City ____________ State ________ Zip ________

Additional Insurance

Insured's Name ____________________ Relationship ____________

Birthdate ____________ Social Security # ____________

Employer ____________________ Occupation ____________

Insurance Co. ____________ Group # ____________ Employee # ____________

Ins. Co. Address ____________ City ____________ State ________ Zip ________