HEALTH HISTORY AND PATIENT INFORMATION

Who may we thank for referring you to our office?_____

PERSONAL INFORMATION

Patient's Name _____ Nickname_____Age _____
Last First MI

Address _____
Street City State Zip Code

Telephone (____) _____ Cell (_____)_____

Date of Birth_____ Sex_____ School _____ Grade _____

Name of Parent(s) / Responsible Guardian(s)_____ SS# _____

Name of Emergency Contact (other than parent/guardian)_____ Telephone (_____) _____

Name of child's physician_____Date last seen _____

Reason for bringing the child to the dentist_____

INSURANCE INFORMATION

Is your child covered by a dental insurance plan? Yes_____ No_____

Name of insurance_____ Group / Policy # _____

Name of parent/guardian insured _____Social Security # of parent/guardian _____

Date of birth of parent/guardian_____ Has the child received previous dental care under this plan Yes_____ No _____

HISTORY	YES	NO
1. Has your child ever required hospitalization for more than 24 hours?	❑	❑
2. Has your child ever received general anesthesia?	❑	❑
3. Does your child have any food or medication allergies? If yes, what? _____	❑	❑
4. Is your child currently taking any medications? If yes, what? _____	❑	❑
5. Has your child ever been seen by a dentist before? If yes, when was their last visit? _____ Name of the doctor _____	❑	❑
6. Has your child ever received any form of fluoride? If yes, what? _____	❑	❑
7. Does your child suck his/her thumb/fingers or a pacifier?	❑	❑
8. Are your child's teeth brushed daily? If yes, how many times? _____	❑	❑
9. Docs your child use toothpaste If yes, what kind? _____	❑	❑
10. Is your child still bottle/breast feeding? If no. at what age did he/she stop?_____	❑	❑

Has your child had any medical problems in the following areas? Please check all that apply.

- ❑ Blood
- ❑ Bones
- ❑ Endocrine
- ❑ Eyes, ears. nose, throat
- ❑ Gastrointestinal
- ❑ Heart
- ❑ Kidney/bladder
- ❑ Liver
- ❑ Muscles
- ❑ Nervous system
- ❑ Skin
- ❑ Tonsils/adenoids

❑ This child had NOT had treatment for any of the above.

Has a physician ever diagnosed this child with any of the following medical conditions? Please check all that apply.

- ❑ ADD/ADHD
- ❑ Allergy
- ❑ Arthritis
- ❑ Asthma
- ❑ Autism
- ❑ Brain injury
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Cleft lip/palate
- ❑ Convulsions/seizures
- ❑ Developmental delay
- ❑ Diabetes
- ❑ Emotional disturbance
- ❑ Epilepsy
- ❑ Eye problems
- ❑ Excessive bleeding
- ❑ Fainting
- ❑ Hearing loss
- ❑ Heart disease
- ❑ Heart murmur
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Leukemia
- ❑ Mental retardation
- ❑ AIDS
- ❑ HIV
- ❑ Nutritional deficiency
- ❑ Orthopedic problems
- ❑ Rheumatic fever
- ❑ Scoliosis
- ❑ Sickle cell anemia
- ❑ Spina Bifida
- ❑ Syndrome
- ❑ Other

❑ This child has never been diagnosed with any of the above conditions.

Is there anything else you think we should know about this child so that we may better meet his treatment needs? _____

_____

_____

_____ Signature of person completing this form

_____ Relationship to the patient

_____ Date

DO NOT WRITE BELOW THIS LINE

Medical History Summary

_____

_____

_____

SBE Recommendations

_____

_____

Dental History Summary

_____

_____

mzl DENTAL

Lago, Zicherman & Associates
quality dentistry & orthodontics since 1975

I understand that I am financially responsible for all dental services rendered. As a courtesy, MZL Dental will submit insurance claims on my behalf.

All insurance claims that are not paid within ninety (90) days will become my responsibility and prompt payment is then expected.

Note: Estimated insurance payment is only an estimate and may not be accurate. It may vary according to the guidelines of my specific insurance policy. Any and all disputes, regarding a dental claim payment, are between you and your insurance company.

Thank you for your cooperation.

Signature _____ Date _____