CAMPBELL
PEDIATRIC DENTISTRY

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WELCOME TO OUR PRACTICE!

Please take a few minutes to complete the following information so we can better care for your dentistry needs.

Today's Date _____ **CHILD (UNDER 18) HEALTH HISTORY**

PATIENT INFORMATION

Patient's Name_____ Birthdate_____ Age _____☐Male ☐Female
Home Address _____ Home Phone_____
City _____ State _____ Zip _____ Mobile Phone_____
School_____ City_____ Grade _____ Email _____
Sister(s)/Age(s) _____ Brother(s)/Age(s) _____

PARENTS / GUARDIANS

Name/Relationship_____ Name/Relationship _____
Email _____ Email _____
Address _____ Address _____
City _____State _____ Zip _____ City _____State _____ Zip _____
Occupation _____ Occupation _____
Employer _____ Employer _____
Business Phone _____ Business Phone _____
Mobile Phone _____ Mobile Phone _____
Has any other member of the family been a patient at this office? Names:
_____ Who may we thank for referring you?_____
In case of emergency, who should we contact? _____ Phone _____

PATIENT MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____
Is the patient currently under medical treatment?_____ Is the patient taking any medications? _____
Has the patient ever had any serious illness and/or operations? _____
Has the patient had allergic reactions to any drugs or medications? _____ If yes, which ones?_____
Does the patient have allergies to nickel or latex? _____ (Women only) Is the patient pregnant? _____
Please check the box for each medical condition that applies:

Hyperactivity (ADD/ADHD)	Y☐ N☐	Reports of grinding teeth	Y☐ N☐	Snoring	Y☐ N☐
Mouth breathing	Y☐ N☐	Sinus Problems	Y☐ N☐	Frequent Colds	Y☐ N☐
Asthma/Hay Fever	Y☐ N☐	Tonsils/Adenoids Removed	Y☐ N☐	Mood swings	Y☐ N☐
Sleep Study conducted	Y☐ N☐	Frequent Headaches	Y☐ N☐	Epilepsy	Y☐ N☐
Speech impairment	Y☐ N☐	Bone Disorders	Y☐ N☐	High Blood Pressure	Y☐ N☐
Fainting/Dizzy Spells	Y☐ N☐	Artificial Heart Valves	Y☐ N☐	Heart Problems	Y☐ N☐
Kidney Disease	Y☐ N☐	Liver Disease	Y☐ N☐	Motor Difficulties	Y☐ N☐
Nervous Problems	Y☐ N☐	Pneumonia	Y☐ N☐	Radiation Treatment	Y☐ N☐
Thyroid Problems	Y☐ N☐	Arthritis/Rheumatism	Y☐ N☐	Tuberculosis	Y☐ N☐
Restless sleep	Y☐ N☐	Cancer	Y☐ N☐	Stroke	Y☐ N☐
Fatigue	Y☐ N☐	Diabetes	Y☐ N☐	Stomach Ulcer	Y☐ N☐
Loss of interests	Y☐ N☐	Bleeding Excess	Y☐ N☐	Hearing Issues	Y☐ N☐

☐Other _____

OVER →

Patient Name _____

PATIENT DENTAL HISTORY

Previous Dentist's Name _____ Date of last visit _____
Date of last complete full mouth X-rays and/or Panorex X-ray _____
Please check the box for all that apply:

☐ Bleeding Gums ☐ Blisters on Lips/Mouth ☐ Prone to Cavities ☐ Missing Teeth
☐ Extra Teeth ☐ Any Teeth Extracted ☐ Chewing Difficulties ☐ Speech Difficulties
☐ Tooth Grinding/Clenching ☐ Severe Head and/or Facial Injuries_____
☐ Pain or Clicking in the Jaw Joint (TMJ/TMD)
☐ Jaw Locking on Opening or Closing _____

Are you currently experiencing dental pain or discomfort? If yes? _____
Are your teeth sensitive to hot, cold, sweets, or pressure?_____
Do you suffer from sleep apnea or snoring?_____
Do you suffer from dry mouth?_____
What if anything, are you looking for in a pediatric dentist?

PRIMARY DENTAL INSURANCE

Person responsible for account (Last, First, MI) _____
Relationship to patient _____ Birthdate _____ Soc. Security # _____
Address _____
City _____ State _____ Zip _____ Home Phone _____
Responsible party employed by _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____ Insurance Phone _____
Insurance Company Address _____
Subscriber ID # _____ Group #_____

ADDITIONAL DENTAL INSURANCE

Insured Name (Last, First, MI) _____
Relationship to patient _____ Birthdate _____ Soc. Security # _____
Address _____
City _____ State _____ Zip _____ Home Phone _____
Insured employed by _____ Business Phone _____
Insurance Company _____ Insurance Phone _____
Insurance Company Address _____
Subscriber ID # _____ Group # _____

HIPAA COMPLIANCE DISCLOSURE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by the OSHO, the CDC, and the ADA.
I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. I authorize release of any information regarding my treatment to my dental/medical insurance company. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical/dental health

Signature _____Date _____

Doctor's Signature_____Date_____