Welcome

Health History Form

Frisco Pediatric Dentistry
Diane L. Lide, D.D.S.
5225 Independence Pwky, Suite 300
Frisco, TX 75035
(972) 377-8444

For your convenience… Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Nickname_____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate _____/_____/_____ Child's Age _____

Child's Home # (_____)_____

Child's Home Address:_____

_____
City State Zip

2. Mother's Information

Name _____

☐ Mother ☐ Stepmother ☐ Guardian

Birthdate _____/_____/_____

☐ Single ☐ Married ☐ Divorced ☐ Separated
☐ Widowed ☐ Partnered ☐ Remarried

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

3. Father's Information

Name _____

☐ Father ☐ Stepfather ☐ Guardian

Birthdate _____/_____/_____

☐ Single ☐ Married ☐ Divorced ☐ Separated
☐ Widowed ☐ Partnered ☐ Remarried

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

4. Who is Accompanying the Child Today?

Name _____

Relationship_____

Do you have legal custody of this child? ☐ Yes ☐ No

5. How did you hear about our office? (check as many as apply)

- ❑ Google
- ❑ Yahoo
- ❑ Bing
- ❑ Yelp
- ❑ Facebook
- ❑ Twitter
- ❑ YP
- ❑ Angie's List
- ❑ Drive-by
- ❑ Doctor's office (name)_____
- ❑ Friend/Family (name)_____
- ❑ School (name)_____
- ❑ Other_____

6. Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

_____
City State Zip

Home # (_____)_____

Work # (_____)_____

Cellular # (_____)_____

E-mail _____

7. 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 _____

8. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Why did you leave your previous dentist?_____

_____

What did you like most about any dentist you have seen?_____

_____

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 the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Pacifier Y N Thumb / Finger Sucking

Y N Nightime Nursing / Bottle/Sippy Cups

Has the child experienced problems with previous dental work?

Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

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

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

Floss his / her teeth daily? Yes No

9. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Sensory Processing Issues
Y N Aspergers, Autism/Autistic Spectrum Disorder

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____)_____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

☐ Good ☐ Fair ☐ Poor

10.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. **I authorize the dental staff to perform the necessary dental services my child may need including nitrous oxide.**

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

For Office Use Only

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

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

Diane L. Lide, DDS, PC

Frisco Pediatric Dentistry

AUTHORIZATION FOR A MINOR CHILD

Child(ren)'s full name(s):_____

DOB(s):_____

I, _____(Parent or Legal Guardian) give_____(Authorized person's full name) permission to accompany my child to the office of Frisco Pediatric Dentistry for dental appointments. I also give permission to _____ (Authorized person's full name) to make necessary decisions regarding dental treatment for my child including, but not limited to:

· The consent for this authorized person to accompany my child for exams, dental cleanings or restorative treatment and to discuss post-operative instructions.

· The consent the staff of Frisco Pediatric Dentistry to discuss finances (treatment charges, account balances, next visit charges) with this authorized person.

· The consent for this authorized person to discuss my child's dental findings, future dental treatment needs and any pertinent personal health information (PHI).

As the parent or legal guardian, I understand that I must present to the office, in person, to sign any treatment plans or informed consents before any restorative procedures or invasive dental treatment can be performed for my child. I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings the child, or no treatment will be performed for my child.

_____

(Signature of Parent or Legal Guardian) (Date)

_____

(Frisco Pediatric Dentistry Representative) (Date)

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