

# Welcome

Brent L. Holman DDS PC



## Health History Form

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

Hobbies \_\_\_\_\_

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (if different from child's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_

Marital Status:

- Single  Married  Partnered  Widowed  
 Divorced  Separated

### 3. Father's Information

Name \_\_\_\_\_

Father Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (if different from child's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_

Marital Status:

- Single  Married  Partnered  Widowed  
 Divorced  Separated

### 4. Who may we thank for referring you to our office?

\_\_\_\_\_  
\_\_\_\_\_

### 5. Ways in which we can communicate with you:

Phone \_\_\_\_\_

Text \_\_\_\_\_

Email \_\_\_\_\_

### 6. Relative or Friend not living with you

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone # \_\_\_\_\_

### 7. Primary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_

Subscriber ID # \_\_\_\_\_

Group # \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

### 8. Secondary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_

Subscriber ID # \_\_\_\_\_

Group # \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

Today's Date: \_\_\_\_\_

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### 9. Dental History

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

Date of your child's last visit to the dentist? \_\_\_\_\_

Who was your child's previous dentist? \_\_\_\_\_  
Name

Address \_\_\_\_\_ Phone \_\_\_\_\_

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 Lip Sucking / Biting       Y  N Nail Biting
- Y  N Nursing / Bottle Habits     Y  N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated 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**

### 10. Health History

Has the child ever had any of the following conditions?

- |   |  |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding         | <input type="checkbox"/> Y <input type="checkbox"/> N Special Needs/Disabilities     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs    | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays        | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease/Murmur           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations            | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Blood Disorders     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                    | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                    | <input type="checkbox"/> Y <input type="checkbox"/> N HIV + / AIDS                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Birth Defects  | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Conditions        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy      | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pregnancy                 | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Latex Product     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis              | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD                  | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints/Valves |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Metal/Nickel |  |

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**

**11.** 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.

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 \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_