Andrew Hoffman DMD

CHILD HEALTH HISTORY UPDATE

Today's Date ____/____/____

PATIENT INFORMATION

First Name _____ Last Name _____
DOB ____/____/____ Age _____
Home Address _____ City _____ State _____ Zip _____

PARENTAL/GUARDIAN INFORMATION

First Name _____ Last Name _____ DOB ____/____/____
Your Home Address (if different from child's):
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____ Cell Phone (_____) _____
Preferred Phone Number: ❍ Home ❍ Work ❍ Cell E-mail Address _____

DENTAL INSURANCE INFORMATION

Dental Coverage? ❍ Yes ❍ No If yes, complete the following:
Primary Insurance Company Name _____
Insurance Company Address _____ City _____ State _____ Zip _____
Insurance Company Phone Number (_____) _____ ID# _____
Group Name _____ Group# _____ Policy Holder's Name _____
DOB ____/____/____ Soc. Sec. # _____ Employer _____
Secondary Insurance Company Name (if applicable) _____
Insurance Company Address _____ City _____ State _____ Zip _____
Insurance Company Phone Number (_____) _____ ID# _____
Group Name _____ Group# _____ Policy Holder's Name _____
DOB ____/____/____ Soc. Sec. # _____ Employer _____

MEDICAL HISTORY UPDATE

Is your child currently under the care of a physician? ❍ Yes ❍ No Reason _____
Physician's Name _____ City _____ State _____ Phone # (_____) _____
Your child's current physical health is: ❍ Excellent ❍ Good ❍ Fair ❍ Poor Are your child's immunizations current? ❍ Yes ❍ No
Please list any current surgeries/hospitalizations since your child's last visit (include dates): _____
_____
Has there been any change in your child's general health since his/her last visit? ❍ Yes ❍ No
If yes, please explain: _____

MEDICAL HISTORY UPDATE (cont.)

Please complete the checklist if your child has experienced any of the following diseases, conditions or procedures since his/her last visit:

ADD/ADHD	❍ Yes ❍ No	Developmental Delay	❍ Yes ❍ No	Liver Problems	❍ Yes ❍ No
AIDS/HIV Positive	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No
Alcohol/Drug Use	❍ Yes ❍ No	Ear Aches	❍ Yes ❍ No	Lupus	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Eating Disorder	❍ Yes ❍ No	Measles	❍ Yes ❍ No
Artificial Bones/Joints/Valves	❍ Yes ❍ No	Epilepsy	❍ Yes ❍ No	Mental Health Disorders	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Fainting Spells/Dizziness	❍ Yes ❍ No	Mononucleosis	❍ Yes ❍ No
Autism	❍ Yes ❍ No	Frequent Headaches/Migraines	❍ Yes ❍ No	Mumps	❍ Yes ❍ No
Bleed/Bruise Easily	❍ Yes ❍ No	Gastrointestinal Problems	❍ Yes ❍ No	Rheumatic Fever	❍ Yes ❍ No
Blood Transfusion	❍ Yes ❍ No	Growth Problems	❍ Yes ❍ No	Scarlet Fever	❍ Yes ❍ No
Date(s): _____		Handicaps /Disabilities	❍ Yes ❍ No	Sickle Cell Disease	❍ Yes ❍ No
Brain Injury	❍ Yes ❍ No	Hay Fever/Allergies	❍ Yes ❍ No	Sinus Problems	❍ Yes ❍ No
Cancer/Chemotherapy/Radiation	❍ Yes ❍ No	Hearing Impairment	❍ Yes ❍ No	Speech Problems	❍ Yes ❍ No
Specify: _____		Heart Murmur	❍ Yes ❍ No	Thyroid Condition	❍ Yes ❍ No
Cerebral Palsy	❍ Yes ❍ No	Hemophilia	❍ Yes ❍ No	Tobacco Use	❍ Yes ❍ No
Chicken Pox	❍ Yes ❍ No	Hepatitis Type_____	❍ Yes ❍ No	Tonsillitis	❍ Yes ❍ No
Cleft Lip/Palate	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Congenital Heart Defect	❍ Yes ❍ No	Hives/Skin Rash	❍ Yes ❍ No	Visual Impairment	❍ Yes ❍ No
Convulsions/Seizures	❍ Yes ❍ No	Kidney Problems	❍ Yes ❍ No		

Please list any other serious medical condition(s) since your child's last visit:

What pharmacy do you use most regularly? _____

Location _____ Phone # (_____) _____

Medications and Drug Allergies

Is your child taking any prescription/over-the-counter medications? ❍ Y ❍ N

Please complete the following table regarding your child's current prescription and non-prescription medications:

Medication	Dosage and Frequency	Purpose

Please complete the checklist if your child is allergic or has had an adverse reaction to any of the following since his/her last visit:

Aspirin	❍ Yes ❍ No	Jewelry/Metals	❍ Yes ❍ No	Penicillin	❍ Yes ❍ No
Latex	❍ Yes ❍ No	Sulfa Drugs	❍ Yes ❍ No	Tetracycline	❍ Yes ❍ No
Dental Anesthetics	❍ Yes ❍ No	Iodine	❍ Yes ❍ No	Ampicillin	❍ Yes ❍ No

Please list any other medications or antibiotics your child is allergic to since his/her last visit:

Please list any allergies other than drug allergies since your child's last visit:

DENTAL HISTORY UPDATE

Why has your child come to the dentist today? _____

_____

Does your child require antibiotics before dental treatment? ❍ Y ❍ N

If yes, please explain: _____

Has your child had any problems with the eruption of teeth? ❍ Y ❍ N

Has your child ever experienced jaw joint pain/discomfort (TMJ/TMD)? ❍ Y ❍ N

How many times are your child's teeth brushed per day? _____

How many times are your child's teeth flossed per day? _____

Is your child's home water supply fluoridated? ❍ Y ❍ N

Does your child take fluoride supplements? ❍ Y ❍ N

Does your child use a fluoride toothpaste? ❍ Y ❍ N

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

AUTHORIZATION AND RELEASE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform Dr. Hoffman of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. If Dr. Hoffman accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Andrew Hoffman DMD of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

X Signature of Parent/Guardian: _____ Date: ____ /____/ ____

FOR OFFICIAL USE ONLY

Reviewed by: _____ Date: ____ /____/ ____