**PEDIATRIC DENTISTRY**
**Jeffrey P. Heilig, D.M.D., P.A.**

# Patient Information and Health History

Date: _____

Is this your child's first visit to this dental office? ☐ Yes ☐ No

Name and Ages of Brother(s) and Sister(s) that are already patients here at this office

_____

**Child's Name**:_____ Preferred Name_____ ☐ Male ☐ Female

Date of Birth:_____ Age:_____ School:_____ Grade:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Email (for appointment reminders):_____

Home Phone:_____ Cell Phone #:_____ (if 18 years or older)

## Information about the Child's Parent(s)

Name:_____ ☐ Mother ☐ Father

Cell Phone #:_____ SS#:_____ Date of Birth:_____

Employer:_____ Work Phone #:_____

Dental Insurance Provider_____ Insured ID #_____

Name:_____ ☐ Mother ☐ Father

Cell Phone #:_____ SS#:_____ Date of Birth:_____

Employer:_____ Work Phone #:_____

Dental Insurance Provider_____ Insured ID #_____

Whom may we thank you for referring your child: _____

(If not referred) How did you hear about us? _____

**(Please complete the next page - Thank You!)**

## Dental History

Reason for this dental visit: ☐ 1st dental exam ☐ periodic check-up Other: _____

List any dental concerns: _____

List any history of injuries to the teeth, mouth or head: _____

Date of last dental visit: _____ Reason for visit: _____ Date of last X-rays:_____

Name of previous Dentist: _____ City: _____

Does your child currently have any of these habits? ☐ Pacifier ☐ Thumb / ☐ Finger sucking ☐ Bottle: ☐daytime ☐nighttime

My child uses: ☐ Fluoride Toothpaste ☐ Mouth rinse _____ ☐ Power brush

How do you expect your child to act at this visit? _____

## Medical History

Child's Physician: _____ City: _____ Phone: _____

Date of last physical exam: _____ Results: _____

Y N - Has a **Cardiologist** or other Physician ever told you that your child requires an **Antibiotic** before dental appointments?

Y N - Is your child currently under the care of a Physician (if yes please explain):_____

Y N - Is your child currently taking any medications (if yes please list): _____

Y N - Has your child ever had a reaction or **Allergy to Antibiotics: Amoxicillin Penicillin** _____

Y N - Has your child ever had a reaction or **Allergy to Local Anesthetics** (Lidocaine, Xylocaine or Epinephrine)?

Y N - Has your child ever had a reaction or **Allergy to Latex Gloves,** Rubber or Balloons?

Y N Has your child ever had a reaction to **Milk? Allergy or Lactose Intolerance**

Y N - Has your child ever had a reaction or Allergy to (other) _____

**Please circle each item**: **Y**(Yes) or **N**(No) if your child has/had any of the following Medical problems:

| | | |
|---|---|---|
| Y N - Heart Murmur | Y N - Asthma/ Respiratory | Y N - Fainting |
| Y N - Heart Problems | Y N - Tuberculosis(TB) | Y N - Diabetes |
| Y N - Rheumatic Fever | Y N - Sickle Cell Disease/Trait | Y N - Convulsions |
| Y N - Jaundice (after age 1) | Y N - Hemophilia | Y N - Epilepsy |
| Y N - Hepatitis | Y N - Abnormal Bleeding | Y N - Cerebral Palsy |
| Y N - Bladder / Kidney / Thyroid | Y N - Anemia | Y N - Delayed Intellectual Development |
| Y N - Spina Bifida | Y N - Immune Deficiency | Y N - Emotional / Behavioral |
| Y N - Surgical Shunt | Y N - Hearing Impairment | Y N - Cleft Lip / Palate |
| Y N - Cancer | Y N - Speech Impairment | Y N - HIV + / AIDS |

Other (Please Explain)_____

I understand that the information that 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 also authorize the dental staff to perform the necessary dental services that my child may need during diagnosis and treatment.

Signature:_____ Relationship to child:_____

**The Parent or individual that accompanies the child is responsible for payment at each dental visit.**

Payment Options include: Check Cash American Express Discover Card Master Card VISA CareCredit