Petaluma Dental Group

Child Health History

Please take time to fill out this form completely. The more we learn about you the better care we can provide.
We look forward to working with you to maintain a healthy, happy relationship.

Child Information

Today's Date: _____

Patient Name: _____ Nickname: _____

Age: _____ Sex: _____ Patient DOB: _____

Address: _____ City:_____ State/Zip: _____

Soc. Sec #: _____ Phone: _____

School: _____ Grade: _____

Responsible Party for Making Appointments

First Name: _____Middle Initial: _____ Last Name: _____

Relationship: _____ Home Ph: _____ Cell Ph: _____

Address: _____City: _____State/ Zip: _____

Mother:

First Name: _____ Middle Initial: _____ Last Name: _____

DL #: _____ SSN: _____

Home Ph: _____ Cell Ph: _____

Employer: _____ Occupation: _____ Wrk Ph: _____

Father:

First Name: _____ Middle Initial: _____ Last Name: _____

DL #: _____ SSN: _____

Home Ph: _____ Cell Ph:_____

Employer: _____ Occupation: _____ Wrk Ph: _____

Guardian:

First Name: _____ Middle Initial: _____ Last Name: _____

DL #: _____ SSN: _____

Home Ph: _____ Cell Ph:_____

Employer: _____ Occupation: _____ Wrk Ph: _____

Best Time to Call:

Parent/ Guardian: _____ Day(s): _____ Time: _____

Parent/ Guardian: _____ Day(s): _____ Time: _____

Parent/ Guardian: _____ Day(s): _____ Time: _____

Petaluma Dental Group

Child Health History

Insurance

Primary Insurance:

Subscriber Name: _____ ID Number (On Insurance Card): _____

Birthdate: _____ SSN: _____

Employer: _____ Occupation: _____

Insurance Company: _____ Group No. (Plan or Policy): _____

Secondary Insurance:

Subscriber Name: _____ ID Number (On Insurance Card): _____

Birthdate: _____ SSN: _____

Employer: _____ Occupation: _____

Insurance Company: _____ Group No. (Plan or Policy): _____

Child's Health History

How often does your child brush per day?

_____

How often does your child floss a day?

_____

Has your child ever had any of the following:

Asthma:	Yes ☐ No ☐	Cancer:	Yes ☐ No ☐
Hepatitis:	Yes ☐ No ☐	HIV/ AIDS:	Yes ☐ No ☐
Hemophilia:	Yes ☐ No ☐	Abnormal Bleeding:	Yes ☐ No ☐
Stomach, Liver or Kidney Problems:	Yes ☐ No ☐	Tuberculosis:	Yes ☐ No ☐
Diabetes:	Yes ☐ No ☐	Rheumatic Fever:	Yes ☐ No ☐
Congenital Heart Defect:	Yes ☐ No ☐	Heart Murmur:	Yes ☐ No ☐
Convulsions/ Epilepsy:	Yes ☐ No ☐		

Handicap/ Disabilities

If so, please explain: _____

_____

Please explain any other health issue your child may have: _____

_____

_____