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Child/ Patient Health History

Date

Patients Name ______________________
Address ______________________
City ______________ State ________ Zip ________
Phone Number ______________________
Email Address ______________________
Sex ☐ M ☐ F Birthday ______________________
Hobbies/Interests ______________________
____
How would you like to be addressed?
____
Who has custody of child?
____
Siblings ______________ Birthday ________
Siblings ______________ Birthday ________
Siblings ______________ Birthday ________
Siblings ______________ Birthday ________
How did you hear about us?
____
When is the best time and place to reach you?
____
What school and grade is patient enrolled?
____

Parents, Guardians, and Financially responsible parties

Name ______________ Birthday ________
SSN# ______________________
Relationship to Patient ______________________
Address ______________________
City ______________ State ________ Zip ________
Phone Number ______________ Cell ______________
Work Phone Number ______________________
Email Address ______________________
Responsible for ________ % of fee
Employer ______________________
Insurance Co. ______________________
Primary ☐ Secondary ☐ Other ☐
Group # ______________ ID ______________
Effective Date ______________________

Name ______________ Birthday ________
SSN# ______________________
Relationship to Patient ______________________
Address ______________________
City ______________ State ________ Zip ________
Phone Number ______________ Cell ______________
Work Phone Number ______________________
Email Address ______________________
Responsible for ________ % of fee
Employer ______________________
Insurance Co. ______________________
Primary ☐ Secondary ☐ Other ☐
Group # ______________ ID ______________
Effective Date ______________________

Name ______________ Birthday ________
SSN# ______________________
Relationship to Patient ______________________
Address ______________________
City ______________ State ________ Zip ________
Phone Number ______________ Cell ______________
Work Phone Number ______________________
Email Address ______________________
Responsible for ________ % of fee
Employer ______________________
Insurance Co. ______________________
Primary ☐ Secondary ☐ Other ☐
Group # ______________ ID ______________
Effective Date ______________________

Name ______________ Birthday ________
SSN# ______________________
Relationship to Patient ______________________
Address ______________________
City ______________ State ________ Zip ________
Phone Number ______________ Cell ______________
Work Phone Number ______________________
Email Address ______________________
Responsible for ________ % of fee
Employer ______________________
Insurance Co. ______________________
Primary ☐ Secondary ☐ Other ☐
Group # ______________ ID ______________
Effective Date ______________________

Assignment and Release

I certify that I, and/or my dependents, have insurance coverage with ______________________ and assign directly to Dr. Gilmore all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and disclose to the above-name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will end why my current treatment plan is completed.

____
Signature of Parent/ Guardian

______________ ______________________
Date Relationship to Pt

Dental History

Reason for today visit _____ Dentist _____

Date of last dental visit _____ Date of last dental x-rays _____

How often do you floss? _____ How often do you brush? _____

Place a mark on "yes or "no" to indicate if you have had any of the following.

Bad Breath	YES □	NO □	Lip or cheek biting	YES □	NO □
Bleeding Gums	YES □	NO □	Mouth breathing	YES □	NO □
Blisters on lips or mouth	YES □	NO □	Mouth pain, brushing	YES □	NO □
Burning Sensation on tongue	YES □	NO □	Orthodontic Treatment	YES □	NO □
Chew on one side of mouth	YES □	NO □	Pain around ear	YES □	NO □
Cigarette,Cigar, Pipe Smoking	YES □	NO □	Periodontal treatment	YES □	NO □
Do you use tobacco (snuff)?	YES □	NO □	Sores or growths in your mouth	YES □	NO □
Clicking or popping jaw	YES □	NO □			
Dry Mouth	YES □	NO □	Speech Problems	YES □	NO □
Fingernail biting	YES □	NO □	Thumb sucking	YES □	NO □
Grinding Teeth	YES □	NO □	Tongue Thrust	YES □	NO □
Gums Swollen or Tender	YES □	NO □			
Jaw pain or tiredness	YES □	NO □			

Health History

Physician's Name _____Date of Last Appt._____Allergies_____

Please list any medications you are currently taking? _____

_____

Place a mark on "yes" or "no" to indicate if you have or have had any of the following

AIDS/HIV	YES □	NO □	Psychiatric Care	YES □	NO □
Anemia	YES □	NO □	Radiation Treatments	YES □	NO □
Arthritis, Rheumatism	YES □	NO □	Respiratory Disease	YES □	NO □
Artificial Heart Valves	YES □	NO □	Rheumatic Fever	YES □	NO □
Artificial Joints	YES □	NO □	Scarlet Fever	YES □	NO □
Asthma	YES □	NO □	Sinus Trouble	YES □	NO □
Back Problems	YES □	NO □	Skin Rash	YES □	NO □
Bleeding Problems	YES □	NO □	Special Diet	YES □	NO □
Blood Disease	YES □	NO □	Stroke	YES □	NO □
Cancer	YES □	NO □	Swollen Feet or Ankles	YES □	NO □
Chemical Dependency	YES □	NO □	Swollen Neck Glands	YES □	NO □
Chemotherapy	YES □	NO □	Thyroid Problems	YES □	NO □
Circulatory Problems	YES □	NO □	Tonsillitis	YES □	NO □
Congenital Heart Lesions	YES □	NO □	Tuberculosis	YES □	NO □
Cortisone Treatments	YES □	NO □	Tumor or growth on head or neck	YES □	NO □
Cough, persistent or bloody	YES □	NO □	Ulcer	YES □	NO □
Diabetes	YES □	NO □	Venereal Disease	YES □	NO □
Emphysema	YES □	NO □	Weight Loss, Unexplained.	YES □	NO □
Epilepsy	YES □	NO □	Do your drink alcohol?	YES □	NO □
Fainting or Dizziness	YES □	NO □	How often? _____		
Glaucoma	YES □	NO □	Do you wear contact lenses?	YES □	NO □
Headaches	YES □	NO □			
Heart Murmur	YES □	NO □	**Women**		
Heart Problems	YES □	NO □	Are you pregnant?	YES □	NO □
Kidney Disease	YES □	NO □	Due Date _____		
Liver Disease	YES □	NO □	Are you nursing?	YES □	NO □
Low Blood Pressure	YES □	NO □	Taking Birth control Pills?	YES □	NO □
Mitral Valve Prolapse	YES □	NO □			
Nervous Problems	YES □	NO □			
Pacemaker	YES □	NO □			

Signature of Parent/ Guardian Date