PEDIATRIC DENTAL CENTER OF NORTH IDAHO
PATIENT INFORMATION AND HEALTH HISTORY

Patients Name: _____ Date: _____ DOB: _____

Age: _____ Sex: _____ School: _____ Grade: _____

Address: _____
(Street) (City) (State) (Zip)

Name of child's Physician: _____ Date last seen: _____

PARENTS INFORMATION

Father's Name: _____ DOB: _____
Phone Number: _____
Employer: _____
Social Security Number: _____

Mother's Name: _____ DOB: _____
Phone Number_____
Employer: _____
Social Security Number: _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Is your child covered by a dental insurance plan? YES NO
Name of Insured: _____ DOB: _____
Address of insured (if different than above): _____
Name of Insurance Company: _____ Policy Number: _____

If your child has a secondary dental insurance please fill in below information.
Name of insured: _____ DOB: _____
Address of insured (if different than above): _____
Name of Insurance Company: _____ Policy Number: _____

Is your child eligible for Medicaid? YES NO Policy Number: _____

HISTORY

1. Is your child being treated by a physician at this time? YES NO
   If yes, why: _____
2. Has your child ever been a patient in a hospital? YES NO
   If yes, why _____
3. Is your child allergic to ANYTHING? YES NO
   If yes, what _____
4. Is your child taking any medications? YES NO
   If yes, what _____
5. Has your child ever had a blood transfusion? YES NO
6. Has your child ever been seen by a dentist? YES NO
   Name of Dentist _____ Date last seen: _____
7. Has your child ever received fluoride in any form? YES NO
   If yes, what: _____
8. Does your child suck their thumb? YES NO
9. Are your child's teeth brushed more than once a day? YES NO
10. Is your child nervous or fearful of the dentist? YES NO
11. At what age did your child stop breast/bottle feeding? _____

HEALTH HISTORY INFORMATION

ORGANS AND SYSTEMS

Has your child had any treatment for the following? Please check yes or no:

Yes	No		Yes	No		Yes	No	
☐	☐	Blood – Circulatory	☐	☐	Gastrointestinal (stomach)	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney – Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Heart	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils/Adenoids

☐ This child has **NOT** had any treatment for the above.

ILLNESS

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Epilepsy	☐	☐	Polio
☐	☐	Anemia	☐	☐	Eye Problems	☐	☐	Pregnancy
☐	☐	Allergy	☐	☐	Excessive Bleeding Issues	☐	☐	Psychiatric Disorder
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Hearing Loss	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia
☐	☐	Brain Injury	☐	☐	Hepatitis-Type: _____	☐	☐	Scoliosis
☐	☐	Bronchitis/Pneumonia	☐	☐	Jaundice	☐	☐	Sinus Problems
☐	☐	Cancer	☐	☐	Leukemia	☐	☐	Snoring at night
☐	☐	Cerebral Palsy	☐	☐	Measles	☐	☐	Frequent Sore Throat
☐	☐	Chicken Pox	☐	☐	Mental Retardation	☐	☐	Spina Bifida
☐	☐	Cleft Lip/Palate	☐	☐	Mumps	☐	☐	Syndrome _____
☐	☐	Convulsions/Seizures	☐	☐	Mouth Breathing	☐	☐	Tetanus
☐	☐	Diabetes	☐	☐	Nutritional Deficiency	☐	☐	Tuberculosis
☐	☐	Diphtheria	☐	☐	Orthopedic Problems	☐	☐	Venereal Disease
☐	☐	Drug/Alcohol Abuse	☐	☐		☐	☐	Whooping Cough

☐ **This child has never been diagnosed as having any of the above conditions/illnesses**

Is there anything else you think we should know about your child? _____

_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS, I WILL NOT HOLD DR. JOHN R. UKICH, OR ANY OF STAFF MEMBERS RESPONSIBLE FOR ANY ERRORS OR OMISSIONS I MAY HAVE MADE IN THE COMPLETION OF THIS FORM

_____ _____

Signature of parent/guardian Relationship to patient

DO NOT WRITE BELOW THIS LINE

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Date: _____ **Height:** _____ **%:**_____ **Weight:** _____ **%:** _____

Medical History Summary

Summarize from patient interviews or Medical Record. Include precautionary measures for Dental Care.

_____

_____.

SSE Recommendations: _____ **ASA:** _____

Dental History Summary

Summarized briefly from Patients past history and Dental experience.

_____

_____

_____.