**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: \_\_\_\_\_\_\_\_\_\_ Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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** 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 Intellectual Disability 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**
=============================================================================================

**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.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.