www.hilliardpediatricdentistry.com

5138 Norwich Street • Hilliard, Ohio 43026
Phone: 614-876-5500 • Fax: 614-876-8773

PATIENT HEALTH HISTORY

Child's Full Name: _____

Preferred Name: _____ Date of Birth: _____

Biological Gender: ☐Male ☐Female

Identify Gender As: ☐Male ☐Female ☐Other

Primary Parent / Guardian Name: _____

Relationship to child: _____ ☐Single ☐Married ☐Other

Secondary Parent / Guardian Name: _____

Relationship to child: _____ ☐Single ☐Married ☐Other

Child resides with: _____ Siblings: _____

What is the reason for your visit? _____

Who may we thank for letting you know about us? (Referred by) _____

Child's Medical History. Please mark all that apply.

Allergies	☐Yes ☐No	Latex Allergy	☐Yes ☐No
Nut Allergies	☐Yes ☐No	Pre-Medication	☐Yes ☐No
Down Syndrome	☐Yes ☐No	Autism	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Behavioral Issues	☐Yes ☐No
Heart Problems	☐Yes ☐No	Seizures	☐Yes ☐No
Hearing/Speech	☐Yes ☐No	Learning Disability	☐Yes ☐No
Asthma	☐Yes ☐No	Cancer	☐Yes ☐No

Please explain? _____

Any other medical conditions _____

Please explain? _____

Please list any medications currently taking: _____

_____

Reason for medication listed above: _____

Child's Physician & Phone: _____

Has your child seen a dentist before? ☐Yes ☐No

How often does your child brush: _____

Does your child floss? ☐Yes ☐No Does anyone help your child brush/floss? ☐Yes ☐No

Parent/Guardian Information

Primary Parent / Guardian Name: _____

Gender: ☐Male ☐Female Relationship to child: _____

Date of Birth: _____ SSN: _____

Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Number: _____

Employer/Occupation: _____

Secondary Parent / Guardian Name: _____

Gender: ☐Male ☐Female Relationship to child: _____

Date of Birth: _____ SSN: _____

Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Number: _____

Employer/Occupation: _____

Dental Insurance Information

Primary Dental Insurance: _____ Phone Number: _____

Policyholder Name: _____

Subscriber ID: _____ Group #: _____

Secondary Dental Insurance: _____ Phone Number: _____

Policyholder Name: _____

Subscriber ID: _____ Group #: _____

I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of electronic signatures on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services

I hereby certify that I have read and understand the information and that it is accurate and true to the best of my knowledge. I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records to third party insurance companies, payers and/or healthcare practitioners. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my child/dependent.

We ask that appointments be canceled or rescheduled at least 24 hours in advance, as we reserve the right to charge a $50 broken appointment fee.

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare will not be affected if I refuse to sign this form. I understand the information used or disclosed by the recipient may not be subject to federal or state law protecting its confidentiality.

Signature: _____ Date: _____