Mayfield SMILES

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CHILD HEALTH HISTORY FORM

PATIENT INFORMATION

Name: _____ Nickname _____

Male ☐ Female ☐ Date of Birth (M / D / Y) _____/_____/_____

Home Address: _____

City: _____ State: _____ ZipCode: _____

Phone Number: (home) _____

How did you hear of our office? If referred, please indicate by whom _____

PARENT/GUARDIAN INFORMATION:

Mother's Name: _____ Date of Birth _____

Address (if different from above): _____

City: _____ State: _____ ZipCode: _____

Home Phone Number: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Father's Name: _____ Date of Birth _____

Address (if different from above): _____

City: _____ State: _____ ZipCode: _____

Home Phone Number: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Soc Sec # _____

Primary Insurance Company _____ Group # _____

Insurance Company Phone Number _____ Insurance ID # _____

SECONDARY DENTAL INSURANCE

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Soc Sec # _____

Secondary Insurance Company _____ Group # _____

Insurance Company Phone Number _____ Insurance ID # _____

MEDICAL HISTORY

Has the patient ever been under the care of a physician for illness? Yes ☐ No ☐

If Yes, Please explain _____

Is the patient currently taking any drugs or medications? Yes ☐ No ☐

If Yes, Please list and explain _____

Please check **YES** or **NO** if he/she has had any of the following:

	Yes	No
AIDS/HIV	☐	☐
Allergies	☐	☐
Anemia	☐	☐
Asthma	☐	☐
Autism/Aspergers	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Epilepsy/Seizures	☐	☐
Genetic Disorders	☐	☐
Heart Disorders	☐	☐
Hepatitis	☐	☐
Developrmental Disabilities	☐	☐

Allergies:

	Yes	No
Penicillin	☐	☐
Local Anesthetics	☐	☐
Latex	☐	☐
Sulfa	☐	☐
Narcotics (codeine)	☐	☐

Others _____

CONSENT FOR SERVICES

1. I authorize that all information provided is accurate.
2. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.
3. I authorize the use of this signature on all insurance submissions.
4. I authorize the dentist to release all information necessary to secure the payment benefits.
5. I understand thta I am financially responsible for all charges whether or not paid by insurance.
6. I authorize my consent for services.

Signature: _____

Print Name: _____

Relationship to Patient: _____

Date: _____