

## ***Youth Information & Health History***

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Nickname \_\_\_\_\_ Hobbies \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Parent's Name \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Whom May we thank for Referring You \_\_\_\_\_

Name of Person to Contact outside of household: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Relation: \_\_\_\_\_  
Person Responsible for Account: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

### **Primary Insurance Coverage:**

Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Group Policy Number \_\_\_\_\_ Phone #: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS#: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_

### **Secondary Insurance:**

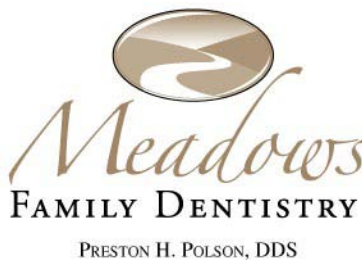
☐ Yes

☐ No

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS#: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_

To the best of my knowledge the information on this form has been answered accurately. I will inform the dental office of any change in the health of my child. I understand that I am financially responsible for all services and fees incurred and that accounts over 90 days are subject to a finance charge that may be calculated at a monthly rate of 1% per month. I understand that any insurance benefits quoted are only estimates and that I am responsible for all services rendered. I authorize all insurance benefits to be paid directly to Meadows Family Dentistry and I further release any information required to process insurance claims. Meadows Family Dentistry is in compliance with the new HIPPA regulations and I have been given the opportunity to review and/or receive the HIPPA regulations concerning the privacy and protection of patient information in their office.

Signature of Parent or Guardian completing the form \_\_\_\_\_



## Youth Patient Information & Youth Health History

(Although oral health primary involves your mouth and surrounding area, your overall health and medical conditions can influence the sequence and appropriate treatment of oral disease. Answers are kept confidential)

### Medical Information

Describe your child's general health:      **Excellent**      **Good**      **Fair**

Yes No

- ☐ ☐ Is your child under the care of a physician? If yes, name of Physician(s) \_\_\_\_\_  
and condition(s) being treated \_\_\_\_\_
- ☐ ☐ Has your child ever been hospitalized or had any operations? If yes explain \_\_\_\_\_
- ☐ ☐ Is your child taking any medicine(s) including OTC or Herbal, if yes list the medication, dosage and how often the medicine(s) taken. \_\_\_\_\_
- ☐ ☐ Is your child allergic to any of the following?  
☐ local anesthetics    ☐ aspirin    ☐ antibiotics    ☐ codeine /narcotics    ☐ latex    ☐ metals(jewelry)  
If yes specify the type of reaction \_\_\_\_\_

### Review of General and Oral Health

(please X if you have or have had any of the following conditions)

- |   |   |   |   |
|---|---|---|---|
| <input type="radio"/> Abnormal Bleeding       | <input type="radio"/> Congenital Heart Defect | <input type="radio"/> Hemophilia            | <input type="radio"/> Mental Health Disorders |
| <input type="radio"/> Allergy/Anaphylaxis     | <input type="radio"/> Dental Trauma           | <input type="radio"/> Hepatitis A, B, or C  | <input type="radio"/> Radiation Treatments    |
| <input type="radio"/> Asthma                  | <input type="radio"/> Diabetes                | <input type="radio"/> Hives/Rash            | <input type="radio"/> Recent Weight Changes   |
| <input type="radio"/> Blood Disease           | <input type="radio"/> Eating Disorder         | <input type="radio"/> Hypoglycemia          | <input type="radio"/> Rheumatic Fever         |
| <input type="radio"/> Blood Transfusion       | <input type="radio"/> Epilepsy/Seizures       | <input type="radio"/> Irregular Heart Beats | <input type="radio"/> Sickle Cell Disease     |
| <input type="radio"/> Breathing Problems      | <input type="radio"/> Excessive Bleeding      | <input type="radio"/> Immune Compromised    | <input type="radio"/> Sinus Trouble           |
| <input type="radio"/> Bruise Easily           | <input type="radio"/> Frequent Cough          | <input type="radio"/> Jaw Popping/Clicking  | <input type="radio"/> Thyroid Disease         |
| <input type="radio"/> Canker Sores            | <input type="radio"/> Frequent Diarrhea       | <input type="radio"/> Kidney Problems       | <input type="radio"/> Tumors or Growths       |
| <input type="radio"/> Chemotherapy            | <input type="radio"/> Frequent Headaches      | <input type="radio"/> Liver Disease         | <input type="radio"/> Ulcers                  |
| <input type="radio"/> Clench/grind your teeth | <input type="radio"/> Heart Murmur            | <input type="radio"/> Lung Disease          |   |
| <input type="radio"/> Cold Sores              | <input type="radio"/> Heart Problems          | <input type="radio"/> Mitral Valve Prolapse |   |

Does your child have any other medical diseases, conditions, or problems not listed above? \_\_\_\_\_

### Dental Information

What is the patient's immediate concern? \_\_\_\_\_

How do you feel about your child's smile? \_\_\_\_\_

Is your child anxious, fearful or have had a past dental experience that has created anxiety? ☐ Yes    ☐ No

Does your family have a current orthodontist? \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_