

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 _____

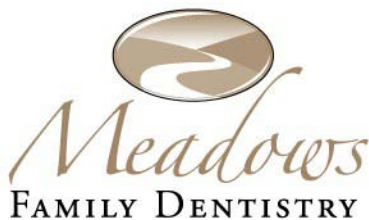
Primary Insurance Coverage:

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 _____



PRESTON H. POLSON, DDS

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 _____