Meadows
FAMILY DENTISTRY
PRESTON H. POLSON, DDS

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 _____

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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 you 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)

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