Child's Health History

Child's Full Name:____ **Nickname/Preferred Name:**______________

Birthdate:____________________ **Gender: Female**____ **Male:** ____ **Number of Children in Family:**_________

Dental History:

Is this your child's first visit to the dentist? ___Yes ___No • If No, name of former Dentist:______________________

Has your child had any dental fear or unhappy dental experiences? ___Yes ____No

Has your child had any of the following:

__ Tooth Pain   __ Tooth Trauma   __ Dental Treatment with Oral Sedation

__ Facial Swelling   __ Cold Sores   __ Dental Treatment with General Anesthesia

Does your child have any of the following habits:

__ Thumb Sucking   __Pacifier Use   __ Snoring   __ Mouth Breathing at Night

__ Lip Sucking   __ Lip Biting   __ Nail Biting   __ Other (explain) :_______________

How often are your child's teeth brushed? __1/day __2/day __Other • With Adult Assistance? __Yes __No

How often are your child's teeth flossed? __Never __ 1/day __ Other • With Adult Assistance? __Yes __No

Does your child use any of the following: __Fluoride Toothpaste __Fluoride Drops/Pills __Fluoride Mouthwash

Does your child drink tap water? __Yes __No • Tap Water Source: __City Water __Well Water __Other

Medical History:

Name of Child's Physician:____ Phone:__________________________

Is your child taking any medications? __Yes __No • If Yes, list:____

Does your child have any allergies? __Yes __No • If Yes, List:____

Has your child ever been hospitalized? __Yes __No • If Yes, reason:_______________________________________

Has your child had any surgeries? __Yes __No • If Yes, list:____

Has your child had any history of:

__Asthma   __Autism   __Bleeding Disorder   __ Chemotherapy/Radiation

__ADD/ADHD   __Diabetes   __Heart Problem   __Developmental Delay

__Hearing Difficulty   __Down Syndrome   __Kidney Problems   __Mental/Emotional Disturbance

__Speech Difficulty   __Seizure Disorder   __Liver Problems   __Cerebral/Spastic Condition

__Sleep Apnea   __HIV/AIDS   __Hepatitis   __Other

If Other, please explain:____

Parent (guardian) Signature:____ **Date:**_______________

Family Information

Maternal Figure: ☐ Biological Mother ☐ Adoptive Mother ☐ Legal Guardian ☐ Foster Mother

NAME:____________________ Soc. Sec #____________ Birthdate:__________

Mailing Address: ____________________ City: __________ State:______ Zip:________

Primary Phone #:______________ CELL/HOME Secondary Phone #:______________ CELL/HOME

Preferred Language: __________ Employer: ______________ Occupation: ______________

Paternal Figure: ☐ Biological Father ☐ Adoptive Father ☐ Legal Guardian ☐ Foster Father

NAME:____________________ Soc. Sec #____________ Birthdate:__________

Mailing Address: ____________________ City: __________ State:______ Zip:________

Primary Phone #:______________ CELL/HOME Secondary Phone #:______________ CELL/HOME

Preferred Language: __________ Employer: ______________ Occupation: ______________

Additional Parental Figure (if applicable): ☐ Step Mother ☐ Step Father ☐ Other __________

NAME:____________________ Soc. Sec #____________ Birthdate:__________

Mailing Address: ____________________ City: __________ State:______ Zip:________

Primary Phone #:______________ CELL/HOME Secondary Phone #:______________ CELL/HOME

Preferred Language: __________ Employer: ______________ Occupation: ______________

In case of emergency, other than those listed above whom may we contact?

NAME: ____________________ Home #: ______________ Cell#:______________

Relationship to patient: ______________________

As a courtesy to you we will be happy to bill your dental insurance for you, provided you have completed this form.

Please check all that apply:

☐ WA State Medicaid, Provider # ______________	☐ No Insurance: Cash Paying
☐ Primary Dental Insurance Subscriber: ______________ Insurance Company: ______________ Group #: ______________ Soc. Sec #: ______________	☐ Secondary Dental Insurance Subscriber: ______________ Insurance Company: ______________ Group #: ______________ Soc. Sec #: ______________

Dr. Ashley has an EXTREMELY Strict No Show Policy:

We strive to stay on schedule. As a courtesy to our patients we will gladly reschedule appointments with 24 hours notice. However, if you were to No Show to an appointment or give less than 24 hour notice to reschedule, a $50.00 No Show/Late Cancellation charge will be added to your account. Multiple No Shows/Late Cancellations will result in PERMANENT DISMISSAL of the ENTIRE family.

No Exceptions.

I have read the office policy and agree to its terms. I understand that the information that I have given today is correct to the best of my knowledge. I will notify the office of any changes directly related to my child, including but not limited to: change of address, change of contact numbers, insurance information, etc. I authorize Dr. Ashley and/or dental staff to perform the necessary dental services my child may need. This may include exams, radiographs, cleanings, topical application of fluoride, restorative dentistry, and/or oral surgery. I understand I am financially responsible for non-covered services, as well as any remaining balance after my insurance company has paid.

Parent/Guardian Signature: ______________________________ Date: __________