Byron R. Rome, DDS, APDC

306 S. Burnside Avenue • Gonzales, LA 70737 • (225) 621-2700 • Fax (225) 644-0493 • www.drromedental.com

Child Health/Dental History Form

TELL US ABOUT YOUR CHILD

Last Name________________ First Name________________ M.I.______
Nickname:____________________ Gender ❑ Male ❑ Female
Birthdate:____/____/____ Age:___ School:________________ Grade:______
Address:________________ City:__________ ST:_____Zip:_____
Home Phone:__________ SS#: __________Email Address:__________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: ____________________ Relation:________________
Do you have legal custody of this child? ❑ Yes ❑ No Whom may we thank for referring you?__________
Other family members seen by us:____________________
Previous/Present Dentist:____________________ Last Visit Date:__________
Parents' marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Partnered

PARENTS' INFORMATION

Mother's Name: ________________ Birthdate: ____/____/____ ❑ Step Mother ❑ Guardian
Home Phone:__________ Cell Phone: __________Work Phone:__________
Employer: ________________ SS#:__________ DL#:__________
Father's Name: ________________ Birthdate: ____/____/____ ❑ Step Father ❑ Guardian
Home Phone:__________ Cell Phone: __________Work Phone:__________
Employer: ________________ SS#:__________ DL#:__________

PERSON RESPONSIBLE FOR ACCOUNT

Name____________________ Relation________________
Billing Address:________________ City__________ ST_____Zip_____
Home Phone:__________ Cell Phone: __________Work Phone:__________
Employer: ________________ SS#:__________ DL#:__________

PRIMARY DENTAL INSURANCE

Insurance Co. Name:____________________
Insurance Co. Address:____________________
Insurance Co. Phone:________________ Group/Plan/Policy #:________________
Policy Owner's Name:________________ Relationship to Patient:________________
Policy Owner's Birthdate:____/____/____ ID#:__________ Orthodontic Coverage ❑ Yes ❑ No
Policy Owner's Employer:________________Address:________________

SECONDARY DENTAL INSURANCE

Insurance Co.:____________________
Address:____________________
Insurance Co. Phone:________________ Group/Plan/Policy #:________________
Policy Owner's Name:________________ Relationship to Patient:________________
Policy Owner's Birthdate:____/____/____ ID#:__________ Orthodontic Coverage ❑ Yes ❑ No
Policy Owner's Employer:________________Address:________________

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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GENERAL INFORMATION

Why did you bring the child to the dentist today?____________________

Has the child ever had a serious/difficult problem associated with previous dental work?.............................. ❑ Yes ❑ No

Is the child's water fluoridated? .... ❑ Yes ❑ No

Is the child taking fluoridated supplements?.. ❑ Yes ❑ No

Has the child ever had any pain/tenderness in her/her jaw joint (TMJ/TMD)? .... ❑ Yes ❑ No

Does the child brush his/her teeth daily?.. ❑ Yes ❑ No

Does the child floss his/her teeth daily?... ❑ Yes ❑ No

Child's Physician:________________ Phone:____________ Last Visit:____________

Is the child currently under the care of a physician?.. ❑ Yes ❑ No

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor

Has your child ever taken Fosamax or any other bisphosphonate?.. ❑ Yes ❑ No

Has your child ever taken Phen-Fen? .... ❑ Yes ❑ No

Please list all drugs that the child is currently taking:____________________

Please list all drugs/materials that the child is allergic to:____________________

Latex? ❑ Yes ❑ No Metals/Nickel? ❑ Yes ❑ No Plastic? ❑ Yes ❑ No

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING PROBLEMS?

Y N		Y N		Y N		Y N	
❑ ❑	Abnormal Bleeding	❑ ❑	Asthma	❑ ❑	Hearing Impairment	❑ ❑	Rheumatic / Scarlet Fever
❑ ❑	ADD/ADHD	❑ ❑	Cancer	❑ ❑	Heart Murmur	❑ ❑	Sickle Cell Disease / Traits
❑ ❑	Allergies to any drugs	❑ ❑	Congenital Heart Defect	❑ ❑	Hemophilia	❑ ❑	Tuberculosis (TB)
❑ ❑	Any Hospital Stays	❑ ❑	Convulsions / Epilepsy	❑ ❑	Hepatitis		
❑ ❑	Any Operations	❑ ❑	Diabetes	❑ ❑	HIV+ / AIDS		
❑ ❑	Artificial Bones/Joints/Valves	❑ ❑	Handicaps / Disabilities	❑ ❑	Kidney / Liver Problems		

Please discuss any serious medical problems the child has had:____________________

DOES / DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y N		Y N		Y N		Y N	
❑ ❑	Lip Sucking / Biting	❑ ❑	Nail Biting	❑ ❑	Nursing Bottle Habits	❑ ❑	Thumb / Finger Sucking

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name:________________ Phone:________________

Address:________________ City:____________ ST:______Zip:______

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____________________ ________________

Signature **Date**

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. *Initials:*________ *Date:*________

Doctor's Comments:________________

Medical History Update

1. Date:________ Signature:____________
Comments:________________

2. Date:________ Signature:____________
Comments:________________