Medical Alert:	Premedication:	Allergies:

DENTAL HISTORY

Does your child have a dental condition about which you are especially concerned? (Yes / No) List Below:

_____

Is this your child's first visit to the dentist? (Yes / No)
Does your child receive dental care on a routine basis? (Yes / No) Date of Last visit: _____
Does your child feel nervous or anxious about having dental treatment? (Yes / No) _____
Has your child had problems with previous dental treatment? (Yes / No) Explain_____
How often are your child's teeth brushed? _____ By whom? _____
Does your child use a manual or electric toothbrush? _____
Is your child receiving fluoride treatments at home or school? (Yes / No) How often? _____
Has your child had orthodontic treatment? (Yes / No) If yes, which office and when: _____
If no, do you feel your child needs orthodontic (tooth straightening) treatment? (Yes / No)
Is your child receiving any speech therapy? (Yes / No) Or had past treatment? (Yes / No) When? _____
Does your child suck his thumb, fingers, or lips? (Yes / No) _____
Is there anything about your child's smile you would like to change or improve? _____

MEDICAL INFORMATION

Medical doctor's Name_____
Address_____ Phone #_____
Is your child currently under the care of a physician? (Yes / No) If Yes, why? _____
Is your child currently taking any medications, prescribed or over-the-counter, including vitamins, supplements and contraceptives? Please List: _____

_____

What is your preferred pharmacy? _____ Phone Number: _____
Is your child **allergic** to any medications or substances such as latex, codeine, amoxicillin, etc? (Yes / No)
List: _____

Please circle if your child has or had any of the following:

Abnormal Bleeding	Bruise Easily	Epilepsy or Seizures	Herpes	Rheumatism
ADD/ADHD	Cancer	Excessive Thirst	High Blood Pressure	Sickle Cell Anemia
AIDS	Chemotherapy/Radiation	Fainting or Dizziness	Hypoglycemia	Scarlet Fever
Allergies	Chest Pain	Frequent Cough	Kidney Trouble	Sinus Trouble
Anemia	Cold Sores	Fever Blisters	Liver Disease	Shortness of breath
Anxiety	Congenital Heart Lesion	Glaucoma	Low Blood Pressure	Stroke
Arthritis/Gout	Cortisone Medicine	Hay Fever	Lung Disease	Swelling of Feet/Ankles, Hands
Artificial Heart Valve	Depression	Heart Murmur	Mental Health Disorder:	Thyroid Disease
Artificial Joints/Hips	Diabetes: Type_____	Heart Pacemaker	_____	Tuberculosis
Asthma	Drug Addiction	Heart Surgery	Nervousness	Ulcers
Autism	Dry Mouth	Heart Trouble	Pain in jaw joints	Venereal Disease
Blood Disease	Eating Disorder: _____	Hemophilia	Parathyroid Disease	X-ray or Cobalt Treatment
Blood Transfusion	Emphysema	Hepatitis: _____	Psychiatric Care	Yellow Jaundice

Have you ever had any other serious illness, condition or surgery not listed above? (Yes / No) If yes, please list with dates: _____

_____

I certify that I have read and understand the above. To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____Date_____
Signature of Parent or Guardian

Reviewed by Doctor/RDH_____ Date _____

Date: _____

Medical Alert:	Premedication:	Allergies:

MINOR HEALTH HISTORY FORM

Name: _____
Last First Middle

Preferred Name: **Male□ Female□** **Birth date:** _____

Brothers and sisters in the family: _____

CONTACT INFORMATION

ADDRESS

_____
_____
_____

Who should be contacted for this account? _____
Best time to contact parent: □ AM □ PM
On the: □ Home □ Cell □ Work

TELEPHONE

Home _____
Mother's Cell _____
Father's Cell _____
Other _____
Email: _____

INSURANCE INFORMATION

FATHER'S INFORMATION

_____
Father's Name Date of Birth

_____
Address (if different from patient)

_____
Employer Work Phone #

_____
Dental Insurance Co. Customer Service Phone #

_____
SSN or Member ID # Group #

MOTHER'S INFORMATION

_____
Mother's Name Date of Birth

_____
Address (if different from patient)

_____
Employer Work Phone #

_____
Dental Insurance Co. Customer Service Phone #

_____
SSN or Member ID # Group #

REFERRAL TRACKING: HOW DID YOU HEAR ABOUT OUR OFFICE?

□Current Patient of ours Name_____
□Doctor Name_____
□Other: Please specify _____
□Drove by and saw office
□Phone Book
□Internet

EMERGENGY CONTACT

_____
Name (other than parents) Relationship to Patient

_____
Home Phone Alternate Phone

ACCOUNT PREFERENCES

Who is responsible for paying for this account?
_____

Would your family like to receive your monthly statements by e-mail? □Yes □ No

At Huckabee & Huckabee our office policy is payment at the time of service. If insurance is involved we will expect your estimated percentage. Our office will not be held responsible for inaccurate insurance estimates. We require a 24-hour notice for any appointment change. If 24-hour notice is not received, there will be a cancelation fee added to your account. This charge is not a covered benefit by your insurance company and will be your responsibility. We will not be able to reschedule any dental appointments until the charge is paid. Monthly late charges will be added to any unpaid balance after 60 days at the rate of 18% APR of the unpaid balance. If a personal check for any payment is returned unpaid, you will be charged a returned check fee of $25.00. If it becomes necessary to turn this account over for professional collection, you will be responsible for their charges as well as your unpaid balance for our services. Should it become necessary to take legal action to collect any unpaid balance, you will be charged for any expenses incurred in connection with such action, including reasonable attorney's fees.

Authorization

I hereby authorize payment directly to Huckabee & Huckabee DDS for group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Huckabee & Huckabee DDS to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history (on reverse) are correct to the best of my knowledge.

Signature of Responsible Party _____**Date**_____

Continued on other side →